

HEALTH STATUS OF CHILDREN, COUNSELING SPECIALTY, AND  
COUNSELOR RATINGS OF ENMESHMENT, RIGIDITY, AND  
IMPACT ON THE FAMILY

By

ROSE DIANE MICHELFELDER MILLER

A Dissertation Presented to the Graduate School of the  
University of Florida in Partial Fulfillment of the  
Requirements for the Degree of  
Doctor of Philosophy

University of Florida

1990  
— — —

Copyright 1990

by

Rose Diane Michelfelder Miller

## ACKNOWLEDGEMENTS

Grateful appreciation is extended to the many individuals who assisted in the completion of the dissertation. I would like to thank Dr. Larry Loesch, whose clarity of thought and purpose guided my efforts. I also wish to thank the other members of my committee, Dr. James Pitts, who offered challenge and encouragement, and Dr. Linda Crocker, who provided consultation and critique.

I would like to thank members of the Florida Association for Counseling and Development for their kind participation in this research. I would like to express my gratitude, in particular, to Dr. Bob Bollett, Dr. Pete Fisher, and Ms. Judy Canning, who, as FACD officers, provided assistance.

I would like to express sincere appreciation to those who aided in videotape production, Greg, Candy, Amber, and Kristin Spires, who shared their wonderful family spirit, and Dr. David Spruill, who generously donated time and professional expertise. I would like to thank Marilyn Meyers-Arvin and Dr. John Poidevant for their collegial support. I would like also to thank Leila Cantara, who assisted in typing and proofreading this manuscript.

Finally, heartfelt appreciation is extended to my family. I would like to thank Adam and Susan, who provided inspiration and encouragement, and Tony, whose confidence and patience, though tested, remained intact.

## TABLE OF CONTENTS

	<u>page</u>
ACKNOWLEDGEMENTS.....	iii
ABSTRACT.....	vii
CHAPTERS	
1 INTRODUCTION.....	1
Theoretical Framework.....	3
Statement of the Problem.....	11
Need for the Study.....	12
Purpose.....	14
Rationale.....	15
Research Hypotheses.....	16
Definition of Terms.....	17
Organization of the Study.....	20
2 REVIEW OF RELATED LITERATURE.....	21
"Psychosomatic" Illness: An Outdated Model.....	21
Changing Needs of Families of Children with Chronic Illness.....	34
Coping Models for Families with Chronic Conditions.....	40
Attitudinal Differences among Counselors.....	59
Summary of the Related Literature.....	64
3 METHODOLOGY.....	66
Independent Variables.....	66
Dependent Variables.....	69
Population.....	71
Sampling Procedures.....	72
Research Design.....	74
Experimental Procedures.....	76
Assessment Instruments.....	78
Research Procedures.....	83
Hypotheses.....	84
Data Analyses.....	85
Methodological Limitations.....	86

4	RESULTS.....	88
	Enmeshment and Rigidity.....	88
	Impact on Family.....	90
5	DISCUSSION.....	93
	Limitations.....	94
	Evaluation of Hypotheses.....	95
	Conclusions.....	96
	Implications.....	98
	Recommendations.....	99
	Summary.....	101

#### APPENDICES

A	LETTERS TO COUNSELORS AND COUNSELOR INFORMATION FORM.....	103
B	INFORMED CONSENT FORM AND FAMILY PROFILE.....	107
C	CLINICAL RATING SCALE (CRS) FOR THE CIRCUMPLEX MODEL OF MARITAL AND FAMILY SYSTEMS.....	109
D	IMPACT ON FAMILY SCALE.....	113
	REFERENCES.....	116
	BIOGRAPHICAL SKETCH.....	132

Abstract of Dissertation Presented to the Graduate School  
of the University of Florida in Partial Fulfillment of  
the Requirements for the Degree of  
Doctor of Philosophy

HEALTH STATUS OF CHILDREN, COUNSELING SPECIALTY, AND  
COUNSELOR RATINGS OF ENMESHMENT, RIGIDITY, AND  
IMPACT ON THE FAMILY

By

Rose Diane Michelfelder Miller

December 1990

Chairman: Larry C. Loesch  
Major Department: Counselor Education

Although recommendations for (family) counseling practice continue to be made based upon the relatively highly criticized theories of "psychosomatic personalities" and/or "psychosomatic families," little is known of the extent to which practicing counselors actually apply these theories. Therefore, investigated in this study were differences in counselors' ratings of family enmeshment, rigidity, and impact of chronic condition on the family as functions of (a) the health status of a child in the family and (b) counselor specialty.

One hundred four practicing counselors from the mental health, marriage and family, and school counseling specialties were randomly assigned to three treatments. In each treatment condition, counselors read a biographical

sketch of a family and viewed a videotaped counseling interview with the family. Family biographical information presented in each treatment condition differed only in regard to the health status of one of two children in the family: (a) bronchial asthma, (b) idiopathic scoliosis, or (c) no chronic condition. Respondents completed the Clinical Rating Scale for the Circumplex Model of Marital and Family Systems and the Modified Impact-On-Family Scale. Factorial analyses of variance were used to evaluate main and interaction effects among the dependent variables.

No statistically significant main or interaction effects were found for counselors' ratings of enmeshment, rigidity, or impact on the family for health status of the child or counselor specialty. It was concluded that, regardless of professional specialty, practicing counselors did not exhibit bias in evaluating important family dynamics based upon the health condition of a child, and therefore that they have not embraced the theories of psychosomatic personalities and/or families. It was recommended that further investigation be made of how a child having a chronic health condition influences family counseling practices.



## CHAPTER 1 INTRODUCTION

In 1984, approximately 10% of children in the United States had some form of disabling condition, with a little less than 2% of those having what is termed physical or orthopedic impairment (National Institute of Handicapped Research, 1985). Similarly, estimates ranged from 7% to 10% for the number of children expected to experience chronic physical illness by the age of 18 (Magrab & Calcagno, 1978; Pless & Douglas, 1971), with approximately half of those children predicted to have asthma (Bronheim, 1978; Matus, 1981; Young, 1980).

While children with physical disabilities may face problems of limited activity and access, medical procedures, expense, and social stigma (Morony, 1981; Wright, 1980), children with chronic illnesses face similar, if less visible, problems. For example, asthma is the leading cause of school absences nationally (Zacharowicz, 1986) and the third leading cause of restricted behavior for people under age 45 (Young, 1980). Other life disruptions for persons with asthma include periodic hospitalizations; uncomfortable medical procedures; giving up favorite pets, foods, and activities;

curtailed vacations; and lack of success in major childhood activities (Golbert, 1985; Kaplan & Sadock, 1985; Matus, 1981; Nieder, 1986). In 1975, almost \$500 million was spent on asthma medications, many of which commonly have adverse side effects (Young, 1980). Asthma is never cured, only managed, and even with modern procedures, some 2,000 to 4,000 people die from it each year (Young, 1980).

The counseling needs of children with physical disabilities and their families have been well documented (Berry, 1987; Opirhory & Peters, 1982; Seligman, 1979; Sonnerschein, 1981; Turnbull & Turnbull, 1985, 1986; Wright, 1980). Most evident in the documentation is a trend toward greater acceptance of and more positive perspectives about these people. Firmly rooted in social and political reform (Greenwood, 1987; Weicker, 1985), these changes in attitudes and approaches have become so ingrained that "it will be very difficult to revert to former positions regarding disability" (Greenwood, 1987, p. 185). Further, although a variety of opinions have been presented regarding differences between theory and actual counseling practices with persons with physical disabilities and their families (Margolis & Rungta, 1986), there is general theoretical consistency in regard to the preferred treatment of disability-related problems.

Unfortunately, similar theoretical consistency does not exist for counseling practices for children with

certain chronic illnesses and their families. Practices for counseling children with asthma are among the most controversial. Asthma is a chronic respiratory illness in which stress plays an important role (Nieder, 1986; Zacharowicz, 1986). The ways that role has been interpreted, however, have a long, complex, and conflicting history (Kaplan & Sadock, 1985; Kuzemko, 1980).

There is evidence that some theoretical perspectives have included unsupported and/or biased assumptions about children with asthma and their families (Bronheim, 1978; Freeman, Feingold, Schlesinger, & Gorman, 1964; Golbert, 1985). It has been suggested that these assumptions continue to negatively influence theories about chronic illness (Coyne & Anderson, 1988; Creer, 1982). However, little is actually known about the impact of these unsupported theories on the clinical assessments counselors make about families with chronically ill children.

#### Theoretical Framework

There is support for the existence of commonalities across chronic conditions and for similar coping-based approaches for families of children with chronic illnesses (Coyne & Anderson, 1988, 1989; Johnson, 1987; McCubbin, McCubbin, Patterson, Cauble, Wilson, & Warwick, 1983; Stein & Jessop, 1982). For example, Stein and Reissman (1980), in a study of families of children with chronic illness, found factors of financial burden, familial/social support,

personal strain, and sense of mastery related to coping level.

Although parents of children with chronic physical conditions face special problems, the prevalence of family dysfunction has not been established. For example, Longo and Bond (1984), in a review of family research comparing families with and without children with disabilities, found no conclusive evidence of differences in family functioning. Studies of families of children with chronic illnesses in general, and of children with asthma in particular, also have resulted in support for heterogeneity among family characteristics (Mattsson, 1975; McLean & Ching, 1973; Nieder, 1986).

A wide variety of theories has been applied to counseling families with disability and chronic illness (Golbert, 1985; Minuchin, Rosman, Baker & Liebman, 1978; Wright, 1980). The assumptions underlying those theories, however, differ significantly. These differences have implications for counseling processes.

#### Models for Counseling Families with Disabilities

Two major assumptions underlie counseling persons with disabilities. The first is the importance of the uniqueness of the individual, i.e., that the counselor avoid stereotypes and focus on the realities of each person's situation (Greenwood, 1987; Laborde & Seligman, 1983; Margolis & Rungta, 1986). The second assumption

relates to the commonality of concerns resulting from disability and implies that the counselor has some knowledge of those concerns. Issues related to coping behavior, grief process, body image, and self-concept reflect the impact of disability on the person (Wright, 1980). It is important to note that these concerns are typically viewed as possible outcomes of disability, not precursors (Shontz, 1977).

These assumptions also apply to theories of counseling for families of children with disabilities.

Psychoeducational counseling approaches to working with biologically based conditions have focused on teaching and learning new methods of life adaptation (Johnson, 1987; Walsh & Anderson, 1987). Other approaches have underscored the importance of the manner in which parents are included (Greenwood, 1987; Moeller, 1986), commitment to the rights of parents to have access to information regarding the impact of the disability (Johnson, 1987; Laborde & Seligman, 1983; Mori, 1983), and avoidance of stigmatizing labels (Margolis & Rungta, 1986; Sonnerschein, 1981).

Using a biopsychosocial perspective, theorists have noted common concerns among families of children with disabilities, including isolation and need for social support (Dunst, Trivette, & Cross, 1986; Moroney, 1981), guilt parents may feel for the child's condition (Featherstone, 1980; Laborde & Seligman, 1983), and impact

of disability on all family members (Fewell, 1986; Mori, 1983; Turnbull & Turnbull, 1986). Developmental theorists have emphasized the need to adapt familial expectations to cognitive, emotional, and interpersonal ability levels of children (Johnson, 1986; Whitt, 1984) and the importance of viewing coping among families with disability as a life-long process (Darling, 1983; Fewell, 1986; Foster & Berger, 1985; Seligman, 1985; Turnbull, Summers, & Brotherson, 1986).

#### Models of Family Dysfunction and Chronic Illness

Theories which have tended to dominate research on the psychosocial aspects of chronic illness have focused on dysfunctionality, rather than coping, among families (Turk & Kerns, 1986). Two theories from which contributions have been drawn in the development of assumptions about asthmatic children and their families in particular are those pertaining to the "psychosomatic personality" and "psychosomatic family."

Psychosomatic personality theory. In 1941, French and Alexander presented a theory of the "psychosomatic personality" postulating that, for children with asthma, wheezing was a symptom of dependency, i.e., a repressed cry for an unloving mother. Thus, for many years, counseling/psychotherapy for the alleviation of asthmatic symptoms focused on the maladaptive asthmatic personality and a faulty mother-child relationship.

There has been little evidence to support the existence of an "asthmatic personality" or associated unique and ineffective mother-child relationships (Buchbinder & Young, 1986; Kuzemko, 1980; Golbert, 1985; Nieder, 1986). In a review of 195 articles, Freeman et al. (1964) found the conclusions presented in them to be based preponderantly on post hoc data from psychiatrically skewed populations, questionable diagnoses, and failure to use "blind" evaluations. Bronheim (1978) later suggested that "with these criticisms in mind, a review of the literature is almost reduced to a presentation of the psychological folklore about asthma" (p. 314). Creer (1982), however, warned

It might seem easy to ignore the conclusions by French and Alexander, but it is impossible to do so. In respect to psychological factors and asthma, their work has easily had the greatest impact on the subject. The ideas expressed by French and Alexander have proven amazingly durable. Despite data to the contrary, they continue to be espoused. (p. 916)

Stern (1981) provided an example of this resilience in a book "dedicated to helping this large group of sufferers, both children and adults, to better understand their illness" (p. vii) in which the following "recurrent themes" among chronic asthmatic families were listed:

1. There is confusion, anxiety, and guilt related to the mother's feelings of inadequacy in her role.
2. There is conflict on the part of the mother over the child's struggle for increased independence.

3. There is manipulation of the child to comply with, and gratify, the mother's narcissistic or neurotic needs.
4. Throughout, there is repeated rejection, repression, and overdependence.

If, as suggested from the data, there are no substantive differences between families of children with asthma and families of children with disabilities (Kuzemko, 1980), this list of "themes" would have to be applied (in an equally inappropriate manner) to the families of children with disabilities. Such a thought is chilling; yet, with perfect seriousness such generalizations have been made about the families of children with asthma (e.g., Wilson, 1980-1981). The unsupported "asthmatic personality" theory, therefore, continues to influence the thinking of mental health professionals.

Psychosomatic family theory. Minuchin and associates (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975; Minuchin et al., 1978) extended the "psychosomatic family" characteristics believed to aid in the development and maintenance of certain chronic illnesses. Based on the case studies of a limited number of families of children with chronic asthma, diabetes, and eating disorders, Minuchin and associates theorized that the illness of the child, or "identified patient," is actually the manifestation of a maladaptive family pattern, which they



characterized as enmeshed, overprotective, rigid, and conflict-avoiding.

Criticisms of the theory of the "psychosomatic family" have emerged from somewhat different sources. A prevalence of "psychosomatic family" characteristics among families of children with chronic illnesses has not been supported (Burbeck, 1979; Johnson, 1986; Kog, Vertommen, & Vandereyecken, 1987; Wirshing & Stierlin, 1979). Instead, what has been documented is the heterogeneity of such families (Mattsson, 1975; McLean & Ching, 1973). Research also fails to support commonality among family characteristics, of any kind, as antecedent to the onset of asthma (Nieder, 1986). Johnson (1987) has questioned the efficacy, and thereby the ethics, of relabeling the problem of the "identified patient" as a family constellation problem. In addition, the characteristics attributed to "psychosomatic families" cannot always be considered maladaptive coping styles. For example, McCubbin et al. (1983) reported that fathers of children with cystic fibrosis "contributed to family interpersonal relationships by reducing conflict by minimizing the open expression of anger, aggressive behavior, and conflictive family interactions" (p. 367). Rather than indicating family pathology common to psychosomatic illness, the characteristics identified by Minuchin et al. (1975) point

toward ways in which some families handle the stresses of illness. Bronheim (1978) suggested

The specificity of family conflict mentioned by Minuchin et al. (1975) may reflect more about the manageability of the stress placed on a youngster and the patterns of reinforcement within the families studied, than it suggests specific familial conflicts as the cause of symptoms. (p. 317)

Perhaps the most serious criticism of the "psychosomatic family" theory, however, questions the interpretation of data presented by Minuchin et al. (1978). Coyne and Anderson (1988) asserted that the data presented "were preliminary and summarized in an impressionistic manner" (p. 113). They maintained that, because this study depended critically on data from children with diabetes, their model had questionable generalizability to other illnesses. Coyne and Anderson also pointed out that, after a decade, "there has still not been a full presentation of the data, and there have been no published replications of the study" (p. 114).

The "psychosomatic family" theory has proven resilient, however. Coyne and Anderson (1988) concluded

Since the publication of Psychosomatic Families, family systems theory has increasingly gained adherents in the field of family medicine. . . . Yet, as one reviewer (Dakof, 1987) has noted, research and theory on families and somatic health still remains stuck at the starting gate. A cursory glance at Social Science Citations Index or Science Citations Index will demonstrate that none of this more recent work has achieved the attention or credibility of Psychosomatic Families. Furthermore, with very few exceptions (e.g., Campbell, 1987), this work

generally accepts the conclusions of Minuchin et al. (1978) without the slightest demur. The kind of critical thinking needed for the vigorous development of the field is too seldom in evidence. (p. 114)

The continuing impact of the "psychosomatic personality" and "psychosomatic family" theories on the literature related to families of children with asthma calls into serious question the degree to which the attitudes and goals of counselors may be influenced by both lack of theoretical congruence and inattention to implications of treatment strategies based on unsupported theory.

#### Statement of the Problem

The "psychosomatic family," along with its predecessor, the "psychosomatic personality," have been challenged as outmoded views of how psychosocial factors are involved in illness (Coyne & Anderson, 1988, 1989; Kaplan & Sadock, 1985). Current models of chronic illness, drawn from psychoeducational, biopsychosocial, and developmental theories which focus on family coping across chronic health conditions and throughout the family life cycle, have achieved increasing support (Johnson, 1987; Rolland, 1987a; Stein & Jessop, 1982; Turk & Kerns, 1986; Walsh & Anderson, 1987).

"Psychosomatic" models, however, have proven to be powerful and resilient influences in mental health fields (Coyne & Anderson, 1988, 1989; Creer, 1982; Golbert, 1985;

Nieder, 1986). The model of "psychosomatic family" functioning has been described by Gurman, Kniskern, and Pinsof (1986) as "one of the most influential bodies of both clinical/theoretical and research investigations in the family field in the last two decades" (p. 573). Coyne and Anderson (1989) voiced concern that while potentially having much to contribute to any comprehensive approach to the treatment of chronic illness, a dismaying number of family counselors were "limited to what they had read in Psychosomatic Families" (p. 139).

Counselors' perceptions apparently reflect these unsupported assumptions about families of children with a "psychosomatic" illness such as asthma. However, it is unknown if counselor's perceptions of families of children with asthma differ significantly from their perceptions of families of children with a physical disability, or families of children with no health concern in defining family concerns and establishing counseling goals.

#### Need for the Study

If it were known whether counselors make different assumptions about families based on health conditions of children, there would be implications for theory, research, training, and practice. Such knowledge would encourage critical appraisal of existing theories of counseling and family health, with continued clarification and modification of those theories as suggested by Dakof (1987)

and Nicolas and Keller (1988). If no differences in assessment are found, then attention could be paid to expanding psychoeducational theories of family coping with chronic health conditions. If differences in assessment are found, then further attention could be given to critical examination of the role of "family psychosomatics" in the development of theories of family health conditions.

This knowledge also would facilitate further research into counselors' assessment of family processes as well as impacts of those assessment processes. If no differences in assessment are found, then the logical next step would be examination of potential differences in treatment and outcomes for families. If differences in assessment are found, then further research focused on counselor assessment processes of families as well as the impacts of misassessment would be warranted. Also of interest would be the manner in which counselors assess influences of impact of biological conditions on families.

This study would have implications for counselor training as applied to the counseling needs of families with chronic physical conditions. If no differences in assessment are found, then counselors could be trained in general assessment techniques for counseling families with special health concerns. If differences in assessment are found, then changes in training regarding counseling needs of families with chronic health conditions would be

required. Training programs would need to explore bias in use of unsupported definitions of families as dysfunctional and aid students in more appropriate methods of family assessment.

For the practitioner, this study would have implications for counseling families with chronic physical conditions. If no differences in assessment are found, then practitioners could consider the effectiveness of services for families with chronic health conditions. If differences in assessment are found, then practitioners would be encouraged to consider current research on special needs of families with chronic health conditions and problems associated with use of unsupported assumptions about these families.

### Purpose

The purpose of this study was to determine the differential effects of presenting physical condition of children on counselor ratings of family function and impact of the chronic condition on the family. Presenting physical conditions of children in this study included bronchial asthma (a "psychosomatic" illness), physical disability, and no chronic illness or disability.

Evaluation of family dysfunction was determined by counselor ratings of degree of enmeshment and rigidity on the revised Clinical Rating Scale for the Circumplex Model of Marital and Family Systems (Olson, 1988b). Impact of

chronic physical conditions on the family was measured by counselor ratings on the Modified Impact-on-Family Scale (R. E. K. Stein, personal communication, 1989), based on a scale developed by Stein and Reissman (1978).

### Rationale

To determine what effect physical condition of child has on counselor ratings of family dysfunction and impact on family, an experimental study was designed. Through random assignment of conditions, this design controlled for extraneous variables and possible threats to internal validity (Campbell & Stanley, 1966).

Three groups of mental health, marriage and family, and school counselors were drawn from members of state branches of the Association for Counseling and Development. Subjects were randomly assigned family profiles indicating bronchial asthma, idiopathic scoliosis, or no illness or disability as a health condition for a child in the family. All three groups of counselors viewed identical videotapes of a family engaged in a semistructured family interview and evaluated the (a) family's level of enmeshment and rigidity and (b) impact of one of three children's health conditions on the family.

Counselor observation of family interaction via videotaped tasks is an established method of collecting information about family interactions (Pinsof, 1981). Rating protocols from the Minuchin et al. study (1978) have

not been published to date and attempts to replicate this study (Kog, Vandereycken, & Vertommen, 1985) have found overlap among characteristics identified in the study. The revised Clinical Rating Scale (Olson, 1988b) is an empirically derived method of measuring enmeshment and rigidity as discrete variables of dysfunctional family organization.

### Research Hypotheses

The following research hypotheses were addressed in this study. The independent variable of major interest was child's health condition. A control variable in this study was counselor's specialty area.

- HO<sub>1</sub>: There is no difference in counselors' ratings of familial enmeshment as a function of child's health condition.
- HO<sub>2</sub>: There is no difference in counselors' ratings of familial enmeshment as a function of counseling specialty area.
- HO<sub>3</sub>: There is no effect on familial enmeshment ratings due to interaction of counseling specialty areas and child's health condition.
- HO<sub>4</sub>: There is no difference in counselors' ratings of familial rigidity as a function of a child's health condition.



- HO<sub>5</sub>: There is no difference in counselors' ratings of familial rigidity as a function of counseling specialty area.
- HO<sub>6</sub>: There is no effect on familial rigidity ratings due to interaction of counseling specialty areas and child's health condition.
- HO<sub>7</sub>: There is no difference in counselors' ratings of impact of chronic condition as a function of child's health condition.
- HO<sub>8</sub>: There is no difference in counselors' ratings of impact on family as a function of counseling specialty area.
- HO<sub>9</sub>: There is no effect on ratings of impact of chronic condition due to interaction of counseling specialty areas and child's health condition.

#### Definition of Terms

For the purpose of this study, the terms listed below were defined as follows:

Bronchial asthma is a chronic, reversible obstructive airways disease (Matus, 1981), characterized by functional abnormality of bronchial smooth muscle, partial or complete reversibility of physiologic abnormality, occurring on an intermittent basis (Creer & Winder, 1986), and estimated to impact about 5% of children in the United States under the age of 15 (Young, 1980).

Idiopathic scoliosis is an orthopedic impairment of unknown causes, characterized by lateral curvature of the spine (Moe & Byrd, 1987; Rangaswamy, 1983). Scoliosis may result from congenital spinal anomalies, neuromuscular diseases, or from unknown or idiopathic causes. Idiopathic scoliosis is the most common form. Idiopathic scoliosis is classified according to first appearance: infantile, juvenile, or adolescent.

Mental health counseling is a counseling specialty which, according to Vacc and Loesch (1987), "emphasizes the provision of services in the community, business or industry, or in private practice" (p. 2). Mental health counseling may include adult, adolescent, child, and family services; prevention and consultation services; and vocational counseling and placement. In this study, a mental health counselor was designated as someone who was trained as a mental health counselor and was currently working as a mental health professional but who was not a marriage and family counseling specialist. Marriage and family counselors were treated separately.

Marriage and family counseling is a counseling specialty which focuses on the family as the primary unit of change (Hollis & Wantz, 1986). In this study, a marriage and family counselor was designated as someone who trained as a marriage and family counselor and was

currently working as a marriage and family counseling professional.

School counseling is a counseling specialty which, according to Vacc and Loesch (1987), focuses on "facilitating the development of children and adolescents, with emphases on interactions among children, school personnel, and parents" (p. 3). In this study, a school counselor was designated as someone who trained as a school counselor and was currently employed as a school counseling professional.

Enmeshment, as hypothesized by Minuchin et al. (1978), is an extreme form of proximity and intensity in family interactions where "changes within one family member or in the relationship between two members reverberate throughout the system" (p. 30). In this study, enmeshment was defined as a rating of dysfunctional family cohesion on the revised Clinical Rating Scale (Olson, 1988b).

Rigidity, as hypothesized by Minuchin et al. (1978), is an insistence in a family on retaining accustomed methods of interaction so that the family is "highly vulnerable to external events" (p. 31). In this study, rigidity was defined as a rating of dysfunctional family adaptability on the revised Clinical Rating Scale (Olson, 1988b).

Impact on the family has been described as factors reported in influencing family life when a child has a

chronic physical condition (Stein & Reissman, 1980). In this study, impact on the family was defined as a rating on the Modified Impact-on-Family Scale (R. E. K. Stein, personal communication, 1989).

### Organization of the Study

The remainder of this dissertation is organized into four chapters. In Chapter 2, the review of related literature is explored. The research methodology and data collection and analyses are described in Chapter 3. The remainder of the study includes Chapter 4, where the results of the study are presented, and Chapter 5, which includes a summary of the study, discussion of results, conclusions drawn from the research, and recommendations.

## CHAPTER 2

### REVIEW OF RELATED LITERATURE

This chapter contains a critique of theoretical and empirical problems in "psychosomatic" illness research. The changing needs of families of children with chronic illnesses and general coping models for families with chronic physical conditions is presented. Client and counselor variables found to account for attitudinal differences among counselors are discussed.

#### "Psychosomatic" Illness: An Outdated Model

Historically, two important lines of investigation have sought to establish links between chronic conditions and family dysfunction: "psychosomatic" medicine and the "psychosomatic" family. These theories proposed that certain disorders have psychological etiologies and can be distinguished by certain dysfunctional characteristics. The assumptions underlying "psychosomatic" theories have been questioned as well as the research literature used to support them.

#### "Psychosomatic" Medicine

Alexander and French (Alexander, 1939, 1941, 1950; French & Alexander, 1941) were early contributors to psychodynamic theories of the role of psychological factors

in chronic health conditions. They explored the ways in which certain organs were innervated by the autonomic nervous system in response to certain specific unconscious repressed needs. Their work included development and/or review of theories about personalities associated with asthma, arthritis, colitis, hypertension, migraine and other conditions.

Other theorists have attempted to link "psychosomatic" illnesses with specific personality characteristics.

Dunbar (1954), in the fourth edition of Emotions and Bodily Changes, expanded the characteristics associated with eight specific illnesses to include not only unconscious conflicts but also specific neurotic traits, family attitudes, and life contexts prior to onset. Ruesch (1948) theorized that ineffective communication between patient and environment was responsible for regressive personalities associated with specific illnesses.

Drawing from Freud's (1961/1910) conversion theories and the work of Cannon (1927) on specific autonomic nervous system reactions to emotions, the French and Alexander (1941) monograph on psychogenic factors in bronchial asthma proposed to illustrate the theory that asthmatic symptoms were the result of the conversion of emotional conflicts through the autonomic system to the respiratory system. Alexander (1941) concluded that asthma attacks were related to an inhibited, suppressed cry for mother's help caused by

the mother forbidding the child to cry, the pride of the child, a "rejecting mother" type, over-emphasis on independence, or a combination of the latter two.

The work of Alexander has been criticized on theoretical and experimental grounds. Kaplan and Sadock (1985) concluded that "even though Alexander's theory of the typical unconscious conflict is a major theoretical force in the psychosomatic field, it remains at this time a basically unvalidated hypothesis, resting on questionable underlying assumptions" (p. 450). Bloom (1988) warned that:

Examining psychological aspects of specific illnesses requires great care in avoiding the psychosomatic fallacy. That fallacy has two components. First is the belief that some disorders have a psychological etiology and some do not. . . . Second is the belief that many illnesses can be distinguished from one another on the basis of their unique psychological characteristics, that is, that there are psychological characteristics that go hand in hand with certain specific disorders. Neither of these assumptions has been shown to have any empirical justification. (p. 209)

Coyne and Anderson (1989) argued against the "psychosomatic" personality on the following theoretical grounds:

While ostensibly explaining how arousal might contribute to physical illness, psychosomatic concepts failed to explain why only some persons became ill or why illness should take a particular form. People can be aroused without becoming ill, and arousal does not necessarily exacerbate the condition of persons already ill. The psychosomatic model also failed to explain how psychological states might translate into the endocrine abnormalities. The very plausibility of

psychological states translating directly into such abnormalities generally depended upon ignorance of identifiable biological pathways. (pp. 140-141)

The declining influence of psychosomatic concepts was evidenced by the deletion of "Psychosomatic Conditions" from the Diagnostic and Statistical Manual III (American Psychiatric Association, 1980).

### "Psychosomatic" Family Study

During the 1970s, Minuchin and associates at the Philadelphia Child Guidance Clinic explored the possible link between the susceptibility to or maintenance of certain physical conditions and certain family characteristics. These researchers (Liebman, Minuchin, & Baker, 1974; Liebman, Minuchin, Baker, & Rosman, 1976; Minuchin et al., 1975; Minuchin et al., 1978) identified "psychosomatic families," or those families whose characteristics, when accompanied by genetic predisposition, placed them at risk for developing and maintaining certain "psychosomatic" illnesses. Coyne and Anderson (1989) concluded:

In the early 20th century, psychosomatic theory became wedded to the psychoanalytic movement, and speculation was focused on how global personality traits might predispose a person to react to stress with a somatic response. Minuchin et al. (1978), thus, borrowed a conceptual strategy from psychosomatic medicine and took it to a higher level of organization--the family--preserving its basic form. (p. 140)

The Philadelphia Child Guidance Clinic researchers were interested in the "transformation of emotional



conflicts into somatic symptoms" (Minuchin et al., 1978, p. 29). These emotional conflicts were theorized to be related to a cluster of five transactional patterns which encourage somatization in severe chronic asthma, diabetes, and anorexia. The transactional patterns theorized to produce somatization were (a) enmeshment, an extreme form of proximity and intensity in family interactions where "changes within one family member or in the relationship between two members reverberate throughout the system" (p. 30); (b) overprotectiveness, a high degree of concern of family members for each others' welfare and hypersensitivity to signs of distress which "retards the children's development of autonomy, competence, and interests or activities outside the safety of the family" (p. 31); (c) rigidity, an insistence on retaining the accustomed methods of interaction so that the family is "highly vulnerable to external events" (p. 31); (d) conflict avoidance, an "inability to confront differences to the extent of negotiating resolution" (p. 32); and (e) the child as part of marital conflict, where the child is "recruited into taking sides by the parents, or intrudes her[him]self as a mediator or helper" (p. 32).

The 45 families who were involved in the "psychosomatic family" study were divided into three "psychosomatic" and two control groups. Assignment to the "psychosomatic" groups was based on physician determination

that frequent and severe symptoms in the families could not be explained on any organic basis. The "psychosomatic" groups included eleven families with children with anorexia, nine families with children with "psychosomatic" diabetes, and ten families with children with intractable asthma. The control groups included seven families with children with "nonpsychosomatic" diabetes and eight families with children with diabetes which was under control but who exhibited behavioral problems.

The "psychosomatic family" study assessed family interaction patterns via a modified Wiltwyck Family Task and examined physiological reactions via free fatty acid (FFA) readings during the Family Diagnostic Interview.

The Wiltwyck Family Task (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) is a structured interview which consists of audiotaped instructions for prescribed family tasks. For the "psychosomatic family" study, a modification of the Wiltwyck Family Task was used (Minuchin et al., 1978). Tasks included (a) choose a dinner menu, (b) describe a family argument, (c) describe something that pleases and displeases you about another family member, (d) make up stories about two pictures of families, and (e) recreate a puzzle as a family.

Responses for the modified Wiltwyck Family Task were coded for interactional patterns of enmeshment, overprotection, conflict avoidance, and rigidity. These

were operationalized at family, subsystem, and individual-interpersonal levels. For example, Minuchin et al. (1978) described enmeshment at the family level as follows:

The extent to which people acted as communication go-betweens was measured, as was the distribution of the spoken transactional sequences to, through, and around certain family members. Shifting alliances, defined as arbitrary and alternating switches of support from one member to another, were rated as an index of overall family enmeshment. All of the factors were seen as indicators of the excessive interdependence of family members. (p. 36)

The assessment of enmeshment at the subsystem level focused on the clarity of boundaries between the parents and the children as follows:

First, the quantity, effectiveness, and unity of the parents' executive behavior in controlling the family in the process of performing the task were objectively rated and counted. Secondly, both cross-subsystem alliances, such as parent and child versus parent, particularly in relation to executive activities, and the executive dominance of one parent as compared to the other were examined, because these factors were considered to reflect the weakening of subsystem boundaries. (p. 36)

The assessment of enmeshment at the individual-interpersonal level was described thusly:

Individual-interpersonal differentiation was reflected in the degree to which individualized percepts and expectations of other family members emerged in each one's likes and dislikes, and in the extent to which family members "read each other's minds" or answered for another person. (p. 36)

Minuchin et al. (1978) maintained that "although these definitions are descriptive and clinical in tone, they represent formal categories whose reliabilities and

significance levels have been established" (p. 36). These data have not been made available however (Coyne & Anderson, 1988; 1989).

The Family Diagnostic Interview (Minuchin et al., 1978) is a videotaped, three-stage interview with intermittent physiological readings of free-fatty acid levels. The Family Diagnostic Interview was designed "to assess simultaneously the child's involvement in parental conflict and the physiological effects of parental conflict on the child's disease" (p. 38). For the "psychosomatic family" study subjects included the three groups of families with diabetes, i.e., those with normal diabetes, those with normal diabetes and behavioral problems, and those with "psychosomatic" diabetes. During stage one parents were asked to discuss a family problem with the child in an observation room. During stage two, the interviewer sought to create or exacerbate conflict over the problem chosen with the child still observing. During stage three, the child was brought into the room and the family asked to decide who they should change to solve the problem. Blood samples were taken during and between stages.

Minuchin et al. (1978) maintained that an overview of the behavioral definitions, quantitative data, and analyses would suffice and that a more detailed report was being

prepared for publication. This report, however, has not been published to date (Coyne & Anderson, 1988; 1989).

On the Wiltwyck Family Task, normal diabetic families were found to differ most from dysfunctional families (i.e., those with diabetics with behavioral problems, or those with anorexia, "psychosomatic" diabetes, or intractable asthma) on indices of enmeshment, with dysfunctional families exhibiting weaker subsystem boundaries and interpersonal differentiation. Families of children with normal diabetes also were found to be less concerned with protectiveness themes, less likely to avoid conflicts, and less rigid in forming alliance patterns within families.

Clinical evaluations of the Family Diagnostic Interview videotapes allowed assessment of three dimensions: (a) activity level, (b) conflict initiation, and (c) conflict level. Indicated in the ratings was little difference among families on activity levels and initiation of conflict. Parents of children with "psychosomatic" illnesses were less intense and confrontive, had fewer discussions about the parental-marital relationship and more discussions about child concerns, than parents of normals. With inclusion of child in stage three, parents of "psychosomatic" children tended to focus less on themselves and more on the child than did parents of normals. Raters also reported more involvement of the

child in coalitions against one parent in "psychosomatic" than in normal families, with families with an anorectic child most extreme.

The researchers reported that evaluations of free-fatty acid results among the three groups of children with diabetes indicated that the "psychosomatic" diabetic group exhibited increasing arousal during the course of the interview, whereas children with diabetes from the normal and the behavioral groups exhibited rises in free fatty acid levels during stages and decreases in levels between stages of the interview.

Minuchin et al. (1978) concluded that the results of this study supported their theory that dysfunctional "psychosomatic" families could be distinguished from normal families based on family characteristics of enmeshment, overprotectiveness, rigidity, conflict avoidance, and involvement of child in parental conflict. They proposed a method of therapy aimed at unbalancing and restructuring these predictable interaction processes.

A chief criticism of the "psychosomatic" family study has been the unavailability of promised research data. Results as presented were vague and impressionistic (Coyne & Anderson, 1988) and operationalizations were loose and incoherent (Kog et al., 1985).

Coyne and Anderson (1988, 1989) summarized concerns about sampling procedures, small sample sizes, experimenter

bias, and inadequacy of data analyses in the Minuchin et al. study (1978). They suggested that categories of families were not as well-defined as purported, citing the difficulty in distinguishing between biological, behavioral self-management, and "psychosomatic" etiology. Sample sizes appeared inadequate for effects reported, with seven to eleven families per group. It also appeared that data on family units were not assessed in the free fatty acid tests; rather, data from only one parent per family were considered.

Following a challenge by Coyne and Anderson (1988) for publication of promised data, Rosman and Baker (1988) presented a sample analysis of the free fatty acid data from the diabetic groups. Coyne and Anderson (1989) judged this data analysis to be inadequate, stating that "correlational analyses utilizing difference scores and a sample size of 7 cannot possibly demonstrate the 'crossover effect' Rosman and Baker claim" (p. 140).

Coyne and Anderson (1988, 1989) also questioned the use of correlational data to imply causality and improper generalizations made from the "psychosomatic" family study. For example, Coyne and Anderson (1988) maintained that rising levels of free fatty acids among children whose diabetes was not in good control could be understood as a symptom of the concern these children and their parents had about their lack of success in treatment, rather than an

indication of some dysfunctional family pattern leading to poor medical outcome. Though the researchers cautioned that results from free fatty acid tests could only apply to diabetic subjects studies, the overriding impressions left by the study suggested common dysfunctional characteristics among all the experimental groups.

Other researchers have failed to replicate the results reported by Minuchin et al. (1978). In a study of 55 females with eating disorders and their families, Kog et al. (1987) failed to find support for "psychosomatic" characteristics, concluding that "neither the symptomatology nor the age of the patient seems to be connected with a particular type of family functioning" (p. 250). Burbeck (1979) found an inverse relationship between severity of condition and "psychosomatic family" characteristics in a study of 42 children with chronic asthma. Kemmer, Bisping, Steingruber, Baer, Hardtmann, Schlaghecke, and Berger (1986) questioned the validity of free fatty acid as a measure of stress based on findings that free fatty acid levels did not change under experimental stress conditions for individuals with diabetes in good control, for individuals with diabetes in poor control, or for individuals without diabetes. In a review of literature focusing on diabetes, Surwit, Feinglos, and Scovern (1983) concluded that "the psychosomatic approach has not been found to be of any



practical utility in helping patients and physicians manage the disease" (p. 256). Loader, Kinston, and Stratford (1980) found no support for a single type of family functioning among children with atopic eczema and their families.

Olson, Russell, and Sprenkle (1983) identified cohesion and adaptability as important variables in family function. Enmeshment and disengagement have been designated as extremes on the cohesion continuum. Rigidity and chaos formed extremes on the cohesion continuum. Enmeshment and rigidity have been described by Minuchin et al. (1978) as dysfunctional characteristics in families with children with chronic illnesses. Barbarin, Hughes, and Chesler (1985), however, found increased cohesion to serve a positive function in families where a child has cancer. Rigidity was viewed as effective coping in a study (Kazak, Reber, & Snitzer, 1988) of families who were successfully maintaining strict diets for children with phenylketonuria (PKU). McCubbin et al. (1983) also found conflict avoidance, another characteristic viewed as dysfunctional in the Minuchin et al. (1978) study, to contribute to family functioning in a study of families with children who have cystic fibrosis.

The "psychosomatic" family study, therefore, has been viewed as an unsupported research, lacking published results and questioned on experimental and theoretical

grounds. This work, however, has been one of the most frequently cited studies in the family therapy field (Forman, 1986). Gurman et al. (1986) maintained:

One of the most influential bodies of both clinical/theoretical and research investigations in the family field of the last two decades has emerged in the work on Structural Family Therapy (Minuchin, 1974; Minuchin & Fishman, 1981), largely at the Philadelphia Child Guidance Clinic (PCGC). Based on a clearly delineated model of the characteristics of psychosomatic family functioning that emphasized enmeshed subsystem boundaries, parental over-protectiveness, behavioral rigidity, poor conflict-resolution skills, and children's involvement in marital conflict, structural therapists have evolved a highly teachable method of therapy aimed at unbalancing and restructuring these predictable interaction processes. (p. 573)

#### Changing Needs of Families of Children with Chronic Illness

There is growing awareness of the needs of children with chronic illness and their families. Indicated in the results of a Vanderbilt University project (Hobbs, Perrin, & Ireys, 1985) was that children with chronic illness, though growing in numbers, have been "a neglected group in our society" (p. 1). While individual illnesses may be highlighted through fund-raising efforts, chronic illness in general has received little attention (Hobbs & Perrin, 1985). Yet, from 10 to 15% of all children experience some chronic health impairment (Gortmacher & Sappenfield, 1984), with over a million children faced with severe, ongoing illness (Perrin & Ireys, 1985).

Chronic illness among children, therefore, can no longer be overlooked as an insignificant concern among

families, requiring that health care providers reexamine beliefs about general characteristics among specific illnesses, differences between chronic and acute disease models, and what constitutes positive coping without inferring pathology among these families.

### General vs. Specific

For many years children with chronic illness and their families have been segmented according to specific illnesses (e.g., cystic fibrosis, diabetes, asthma, renal disease, or cancer), limiting information about the impact of chronic illness to hypotheses about particular groups. This fragmentation led the Vanderbilt researchers (Hobbs et al., 1985) to conclude the following:

Awareness of a particular chronic disease may occasionally be heightened briefly by efforts of a voluntary group to raise money on behalf of children with "its disease." But interest is fleeting. Chronically ill children live out their lives in a twilight zone of public understanding.  
(p. 1)

Research efforts have tended to be equally fragmented so that "only relatively recently has there been much recognition of issues such as impact on family, psychological adjustment, and social development that are common to children with different chronic diseases" (Pless & Perrin, 1985). In a study of across-illness commonalities, Stein and Jessop (1982) found greater variability within diseases than among these diseases on measures of family coping as reported by families

themselves (though physicians continued to predict differences based on type of illness). Other researchers have noted the importance of commonalities of stress and coping among these families and have supported the use of a noncategorical approach to assessing the general impact of illness (Masters, Cerreto, & Mendlowitz, 1983; Starfield, 1985).

Johnson (1987) argued that counselors need to become aware of the general needs among families with biologically based difficulties. Families of children with chronic illnesses have tended to operate in isolation, with few organizations or policies such as those formed to meet the needs of children with physical or developmental disabilities (Hobbs et al., 1985).

### Chronic vs. Acute

Changes in technology have prolonged life and altered expectations for quality of life for children with chronic illness (Walker & Jacobs, 1985). Yet, Perrin and Ireys (1985) concluded:

Along with this remarkable progress have come new problems and demands. Families face years of financial and emotional burden from caring for their ill child; physicians trained to cure must learn new ways of treatment for a child with a long-term but incurable illness. Nurses, who previously focused on acute, in-hospital care, now work with families in many home and community settings to provide a wide array of both traditional and new long-term nursing services. Schools must now integrate into regular classrooms children with illnesses that are frightening to teachers and peers; communities seek ways of embracing these children; society as a whole must

discover how to pay for the ever-accelerating costs of their care. (pp. xvii-xviii)

When compared to children with acute, curable conditions, children with physical and developmental disabilities have been found to face particular problems in the medical community. For example, pediatricians have described themselves as attracted to therapeutic success with relatively healthy children and as disliking work with chronically ill and disabled children (Darling, 1979, 1983). Darling (1983) pointed out that because the primary goal of the "medical model" is to cure, physicians have had to reeducate themselves to better serve children with chronic conditions.

The mental health field also has been asked to rethink attitudes toward chronicity. Darling (1983) maintained that because "psychologicistic theories" are rooted in the belief that conditions can change, problems encountered by families of children with disabilities have been discounted as arising from deficits within the child or family. Counselors have been asked to assess the demands of disability and chronic illness for families across the life span (Fewell, 1986; Foster & Berger, 1985; Seligman, 1985; Whitt, 1984).

#### Coping vs. Pathology

Pathology or dysfunctionality in families with chronic or disabling conditions has tended to be overemphasized (Anderson, Reiss, & Hogarty, 1986; Coyne & Anderson, 1988;

Foster & Berger, 1985; Hatfield, 1982; Masters et al., 1983, Turk & Kerns, 1986). With few exceptions (e.g., McCubbin et al., 1983; Stein & Reissman, 1980; Stein & Jessop, 1982), positive coping among families with illness has been ignored in professional research (Turk & Kerns, 1986).

Studies which have focused on pathology in families with children with chronic illness have been plagued with methodological difficulties. Absence of control groups has been identified as the most serious flaw in research on chronic illness in families (Campbell, 1986; Loader et al., 1980; Turk & Kerns, 1986). Much of the research on families and chronic illness has been cross-sectional, with little attention to stability of characteristics being measured, so that inaccurate typologies have been formed (Turk & Kerns, 1986). The appropriateness of some assessment instruments for individuals with chronic conditions also has been questioned (Masters et al., 1983). Other concerns with family illness research have included the use of correlational data to "explain" causality (Masters et al., 1983; Turk & Kerns, 1986) and overgeneralization of results (Burbeck, 1979; Coyne & Anderson, 1988; Johnson, 1987).

Ill-applied etiology of illness and disability has served to threaten the ways counselors and other professionals relate to families who must cope with these

conditions. Seligman's (1979) review of research on families with disabilities revealed a history of inadequate relationships between parents of these children and the professionals with whom they worked. Parents have been reported to desire an empathic approach (Berry, 1987; Sonnerschein, 1981; Turnbull & Turnbull, 1985) with sound, reality-based guidance (Buscaglia, 1983). Instead, these parents have reported "lack of empathy and understanding by 'professionals' of the parents' concerns, pressures, and goals for their children" (Fox, 1979, p. 36), resulting in a magnified sense of isolation after encounters with professionals (Featherstone, 1980). Sonnerschein (1981) criticized stereotypes of parents of children with disabilities (e.g., less capable and vulnerable, responsible for the child's condition, and inclined to be pushy, angry, denying, or resistant) being used to justify "professional distance."

There has been growing concern that focusing on the parents of children with chronic illness as contributors to the problems of their children may have serious consequences. Anderson et al. (1986) argued that the assumption of family responsibility in illness only adds to family suffering and self-blame. Coyne and Anders (1988) maintained that therapist expectations of dysfunctionality in families with chronic illness were self-confirmatory, leaving those professionals ill-prepared for more effective

approaches. Bruhn (1983) cautioned that preoccupation with techniques based on inadequate theory in effect hampers productive research. Hatfield (1982) warned that assumption of pathology only creates distance between therapists and families who come to them for help. Johnson (1987) charged that misplaced emphasis on pathology ignores the realities of biologically based conditions, thus hampering both the development of theories about families with biologically based conditions and the counseling practices applied to these families.

#### Coping Models for Families with Chronic Conditions

There have been calls for broader understanding of chronic illness and disability than proposed by the "psychosomatic" family model which, Coyne and Anderson (1988) contend, "decontextualizes the family and assigns to it characteristics that are more appropriately seen as reflections of the disease process, the family coping tasks this entails, and the nature of the family's relationship with the health care system" (p. 113). The need for multidisciplinary approaches has been suggested (Campbell, 1986; Dakof, 1987; Johnson, 1987; Kazak, 1989; Nicolas, Gerstein, & Keller, 1988; Turk & Kerns, 1986), to include emphases on family coping with the impact of illness, the family as an open system in interaction with powerful biomedical and institutional factors, the importance of



self-management programs, and the developmental context of the family.

Two studies attempted to identify patterns of coping among families with children with chronic illness. Stein and Riessman (1980), in a longitudinal study of the responses of 100 mothers to the Impact-on-Family Scale, identified dimensions of the impact of illness on these families. Factor analysis revealed four dimensions: (a) financial burden, the economic consequences for the family of the presence of an ill child; (b) social/familial impact, the disruption in normal social interaction both within and outside the family system which is a direct consequence of a child's illness; (c) personal strain, the personal disequilibrium experienced, uncertainty, and difficulty of planning for the future; and (d) mastery, the coping strategies employed by the family to master the stress of illness. While financial burden and mastery were found to be relatively independent factors, a relationship between familial/social impact and personal strain was noted.

McCubbin et al. (1983) found similar patterns of coping in a study of 100 families of children with cystic fibrosis through factor analysis of responses to the Coping Health Inventory for Parents (CHIP; McCubbin, McCubbin, & Cauble, 1979). The three coping patterns which emerged were (a) maintaining family integration, cooperation, and

an optimistic definition of the situation; (b) maintaining social support, self-esteem, and psychological stability; and (c) understanding the medical situation through communication with other parents and consultation with the medical staff.

Areas of commonalities among families of children with chronic illness, therefore, included personal coping, social and family support, contact with health care system, and striving for mastery of health care needs. In addition, researchers have identified the influence of developmental context for the child (Masters et al., 1983; Whitt, 1984) and the family as a whole (Burr, 1985; Drotar, 1981; Rolland, 1987a, 1987b).

#### Personal-Emotional Strain

Families with children who experience chronic illness or disability were found to be no different than control families in terms of family stability and family and individual coping variables (Kuzemko, 1980). There are, however, some indications that these families face similar demands upon their personal and family resources.

Overload. Time demands constitute significant stressors in the lives of families with children who are chronically ill or disabled. Fatigue, lack of free time, and burnout have been identified by parents of children with disabilities (Featherstone, 1980; Harris, 1983). Overload has been found to occur particularly among

mothers, both those acting as primary caregivers (Moeller, 1986; Moroney, 1981) and those attempting to maintain careers outside the home (Mori, 1983). Parents of children with disabilities have reported problems in balancing their own needs with the needs of their families (Mori, 1983), in finding time for themselves as couples (Featherstone, 1980), and in accomplishing the normal daily activities of housekeeping and shopping (Moroney, 1981).

Overload has also been identified as a significant stressor for parents of children who are chronically ill, with fatigue posing a threat to the ability of these families to accomplish basic developmental family tasks, e.g., satisfactory division of labor and maintenance of the home (Burr, 1985). Parents found fatigue, time spent in travel to the hospital, and lack of someone reliable on whom to depend for time away from the children as significant contributors to personal strain (Stein & Reissman, 1980). Fifty-five percent of parents of children with chronic illness have reported fatigue as a significant problem in their lives (Pless & Satterwhite, 1975).

Grief reaction. Parents of children who are disabled have been found to experience reactions to the diagnosis of disability that closely parallel grief reaction as outlined by Kubler-Ross (1969). Though these reactions vary within families (Mori, 1983; Seligman, 1979), common reactions to having a child with a disability have included sorrow,

guilt, shame, anger, frustration, fear, denial, disbelief, helplessness, ambivalence, disappointment, and depression (Featherstone, 1980; Harris, 1983; Laborde & Seligman, 1983; Mori, 1983; Opirhory & Peters, 1983).

Though less researched than parents of children with disabilities, parents of children who are chronically ill also have reported grief reactions. However, these reactions have been described as more cyclical in nature, e.g., parents have identified the "roller coaster" (emotional) existence they experience between crises (Stein & Reissman, 1980) and the burden of living under the "constant shadow" of illness (Massie, 1985). Chronic illness has the potential to deplete emotional resources, lessen morale and motivation, and stifle family planning for the future (Burr, 1985; Drotar, Crawford, & Bush, 1984; Stein & Reissman, 1980).

Financial burden. Parents of children with chronic illness or disability have listed financial burden as a significant factor in the impact of these conditions on their lives (Drotar, 1981; Golbert, 1985; Harris, 1983; Moroney, 1981; Turnbull & Turnbull, 1986). Financial burden is a stressor that all chronic illness diagnoses have in common (Pless & Perrin, 1985). At least 10% of families of children who have a disability reported financial difficulties as a result of the child's condition (National Institute of Handicapped Research, 1985). In a

study of families of children with chronic illness (Pless & Satterwhite, 1975), 65% of the families reported significant financial difficulty. Over half of the families of children with asthma have reported that at least 18% of family income was needed for illness-related expenses (Young, 1980).

In a longitudinal study of families of children with chronic illnesses (Stein & Reissman, 1980), parents identified a need for additional income to cover medical expenses, time lost from work for medical appointments, and hours lost in caring for ill children as contributors to financial problems in the family. Burr (1985) suggested that the cost of chronic illness be measured not only in medical bills but also in lost career mobility for parents who cannot afford to lose insurance benefits by changing jobs. Massie (1985) presented the following viewpoint on insurance practices in relation to chronic illness:

Unfortunately, in America virtually every child and family who struggle with chronic illness must also battle against the enormity and insanity of the American health insurance system. Anyone who has had contact with the gargantuan costs a chronic illness can engender knows that health care in the United States is an empire of inequity, a system that provides extraordinary care to some while largely neglecting others. Insurance companies routinely bar the chronically ill because of their jobs when their employer's insurer complained that their child was going to provide a rate hike for the company. . . . Thus, parents and children must fight not only the disease but sometimes also insurance companies, employers, government agencies, and hospital financial screening offices that create whirlpools of worry that often contribute to the destruction

of the family structure so important to the child's health. (p. 20)

While provisions for health services for persons with disabilities have been in place for many years, these programs have not consistently provided benefits for families with children with chronic illness (Leffert, 1985). Efforts to recognize the needs of families with children who are chronically ill are relatively new and will require major revisions in public health care policy (Hobbs et al., 1985).

Limited activity. Just as children who have disabilities have encountered problems of limited recreation, architectural barriers, and physical discomfort (Habeck, 1984; Henderson & Bryan, 1984; Morony, 1981), children with chronic illnesses have been found to face similar problems of restricted behavior. Not only do these children spend significant numbers of hours in visits to clinics and medical regimes, but also are restricted in the activities they can perform. The restrictions posed by asthma provide an example of these limitations.

Asthma is the leading cause of restricted behavior for children under 17 years of age (Bruhn, 1983), the third leading cause of activity limitations for persons under age 45, and the fifth leading cause for all ages (Young, 1980). Because exercise and other activities have been found to induce asthmatic attacks (Bronheim, 1978; Young, 1980), there have been concerns that restrictions may deny these

children important childhood activities and accomplishments (Golbert, 1985; Kaplan & Sadock, 1985; Matus, 1981; Nieder, 1986). Also, because these attacks have been found to be connected to allergens, many children have had to forego favorite pets, foods, and entertainments (Bronheim, 1978; Golbert, 1985; Nieder, 1986).

Chronic illnesses may also influence school performance. Asthma is the leading cause of school days missed due to illness (Zacharowicz, 1986), accounting for 61.3% of the total days missed. These absences were thought to be particularly critical because they tended to be sporadic and, therefore, would not merit special tutorial programs offered students missing blocks of school days. McLoughlin, Nall, Isaacs, Petrosko, Karibo, and Lindsey (1983) found that though they exhibited no difference from children without asthma on academic skills, children with asthma experienced more attention problems at school than did control group children. Those problems have been related to the use of antihistamines, which may cause drowsiness, withdrawal, or hyperactivity, and the use of bronchodilators, whose side effects include inattentiveness, irritability, hyperactivity, drowsiness, and withdrawal (Nieder, 1986). Fifty-three percent of the parents of children with asthma surveyed by Creer, Marion, and Creer (1983) identified school problems as significant for their children.

### Familial-social support

Social support, an important moderating variable in stressful situations such as illness and disability, has been associated with reduced complications and speeded recovery (Cobb, 1976), increased adherence to medical regimes (Bruhn, 1983), and decreased emotional distress during illness (Lin, Simeone, Ensel, & Kuo, 1979). Social support has been found to be particularly important for families with children who experience chronic illness or disability (McCubbin et al., 1983); Pless & Pinkerton, 1975; Stein & Reissman, 1980; Zacharowicz, 1986). For families of children with disabilities, there is need for support at many levels: from the family, i.e., spouse, other children, and kinship network; from the community; and from social consciousness (Fewell, 1986). Social isolation and stigma, however, have been identified as common problems among these families.

Social isolation. From a review of literature of families of children with disabilities, Morony (1981) found parents of these children to be at risk for social isolation and problems of attitudes of relatives and neighbors. Families of children with disabilities reported less available social support than families of children without disabilities (Dunst et al., 1986). Parents of children with disabilities have been found to withdraw from their circle of friends, citing problems such as difficulty



in obtaining child care (Mori, 1983) and reluctance to call on friends in time of need (Featherstone, 1980).

Families of children with chronic illness also have reported evidence of social isolation. For these families, lack of social support systems limit their mechanisms for sharing the burden of the ill child beyond the family (Burr, 1985). Parents in the Stein and Reissman (1980) study reported giving up travel, evenings out of the home, and time with friends and other family members. These parents also expressed doubts about whether their child should be treated as "special" in the neighborhood and concern about deciding whether they would choose to have more children in the future. In a study of parents of children with asthma (Creer et al., 1983), 32% reported withdrawal from community activities.

Stigma. Societal attitudes have been identified as very real external stressors in the lives of persons with disabilities (Habeck, 1984). Misperceptions of individuals with disabling conditions as inferior, less intelligent, in need of charity, totally impaired, and preferring the company of other disabled persons have been noted (Henderson & Bryan, 1984). The adaptation of children to chronic and disabling conditions has been found to depend in part upon coping strategies and support mechanisms which allow the child to participate as fully as possible in family, community, and regular school activities (Whitt,

1984). Restrictions for some children, however, significantly limit their participation in important childhood activities.

In a classic study of children with polio, Davis (1963) found that children attempting to cope with differences between themselves and "normal" standards adopted three strategies: (a) "passing," i.e., disguising visible signs of impairment; (b) "normalization," i.e., treating differences as unimportant; and (c) "dissociation," i.e., insulating themselves from situations that underscore differences. Matus (1981) reported the potential for similar reactions among children attempting to avoid the stigma of asthma:

It is unfortunate that asthmatic symptomatology and its consequences are manifested to the healthy world in forms that are easy to disparage. This is particularly true in childhood. Consider for a moment a child in respiratory distress, athletically or academically impeded, medically stunted, or cushingoid in appearance. These phenomena can subject a child to ridicule and isolation. In response, a child may develop a low opinion of himself or herself. Several self-defeating options may then result. The child may deny the illness, fail to pay proper attention to it, and thereby increase the risk of attacks or exacerbations. A second option stemming from low self-esteem is to avoid situations that generate ridicule, thus fostering invalidism. Either way, the child is impelled into the asthma culture and away from normal living. (p. 334)

Johnson (1986) suggested that social support be considered an important variable in the study of family adaptation to chronic illness of a child. Margolis and Rungta (1986) cautioned counselors about the importance of

avoiding negative stereotyping in working with special populations. Counselors also have been warned against the tendency to mislabel, e.g., individuals as emotionally disturbed (LaBorde & Seligman, 1983) or families as dysfunctional (Seligman, 1985).

#### Contact with the Health Care System

Families with children with chronic illness or disability must interact with a network outside the realm of most families: the health care system. These children must cope with painful procedures, dreaded hospitalizations, and unfulfilled expectations (Matus, 1981). Parents must try to find their way into and learn to become experts about a system which may or may not invite their participation. The success of family members in these tasks can have significant impact on their abilities to feel in control and masters of their lives.

Search for quality health care. Children with chronic illnesses or disabilities often require access to specialized medical and surgical services not required by other children (Leffert, 1985; Perrin, 1985). Parents need information about the specific conditions of their children and about generic services for children who have chronic illnesses or disabilities, provided in a coordinated and efficient way, available regionally, from skilled and concerned health care providers (Pless & Perrin, 1985; Seligman, 1985).

Much of the research on the care available to children with chronic illness has been based on studies at teaching hospitals where different levels of services are offered than in other parts of the country (Hobbs, Perrin, & Ireys, 1985). It is not uncommon for parents of children with chronic illness to have problems in securing satisfactory professional services for their children (Seligman, 1979; 1985; Young, 1980). The cost of secondary-level specialists may prove prohibitive for some families (Perrin, 1985). Other problems have included a shortage of specialists (Young, 1980) and distance from major medical centers (Hobbs & Perrin, 1985).

Patient-physician relationships. Another important consideration in quality care is the patient-physician relationship. There has been some evidence that physicians evade social-emotional issues in the care of adolescents with chronic conditions (Raimbault, Cachin, Limal, Elincheff, & Rappaport, 1975). Massie (1985) voiced extreme respect for concerned physicians who take time to answer questions and listen to worries, but criticized those who behave differently:

Some doctors and medical students apparently think that when they are brisk in manner they are being professional. In fact, they are being bad doctors. The art of medicine involves a commitment to the patient as person, and that person is often scared and uncertain, desperate to ask questions but intimidated by the doctor's demeanor and obvious impatience. This is especially true for patients who are children and for their young parents. (p. 20)

Communication with the medical staff has been identified as an important area of coping for parents of children who have chronic illnesses (McCubbin et al., 1983). However, little research in the area of parent-physician interaction exists (Johnson, 1986). Areas for further research include (a) explicitness of instructions, (b) shared expectations, (c) patient assumptions about responsibility, and (d) positive and supportive clinical-patient interaction (Bruhn, 1983).

### Mastery

An important factor found to mediate the impact of illness upon the family is the degree to which the family has learned to "manage" the illness. Access to information about the illness or disability that affects their children and involvement in health management programs have been found to increase sense of mastery. Families with a sense of mastery reported that they felt better about themselves, closer as a family, and more able to treat their child as "normal" (Stein & Reissman, 1980).

Need for information. Children with chronic illnesses need practical information and a sense of control and mastery; "without adequate knowledge, the child has no way to deal adequately with the problem" (Matus, 1981, p. 334). Informational and self-management programs have been proven effective for these children. For example, information and experience with a particular illness has been found to be

associated with children experiencing less stress about being diagnosed as having that illness (Marteau & Johnson, 1986). In addition, a more active role for children in treatment has been found to be associated with enhanced adherence to those treatment regimes (Bruhn, 1983).

When faced with hospitalization, children who saw informational films about hospital and surgical procedures have had more positive outcomes than children who did not (Melamed & Siegel, 1975). Programs proven effective have focused on the following real or imagined dangers in hospitalization: (a) fear of discomfort, pain, or death; (b) anxiety associated with separation from parents and friends; (c) fear of the unknown; (d) uncertainty about limits and expectations; and (e) relative loss of control, autonomy, and competence (Wolfer & Visintainer, 1975).

Self-management skills. Competence/coping-based models for children with chronic illness have also proven effective in improving overall quality of life (Creer, 1982; Drotar, 1981; Johnson, 1987). For example, self-management programs for children with asthma have proven successful in reducing school absences and medical expenses (Creer, 1982) and in improving school grades and participation (Clart, Feldman, Evans, Wasilewski, & Levinson, 1984).

Drotar (1981) concluded that a quality comprehensive program for children with chronic illnesses include

parental participation. Innovative programs have been developed which provide informational films for families, family advocacy and coordination efforts, peer counseling programs, self-management video games and stress reduction programs for children, and home visitation programs (Hurley, 1987). Other hospitals have developed "parent care units" which serve to train parents in cost-effective programs (Johnson, 1986). These programs recognize the impact of illness on the entire family and see parents as integral parts of a quality health care program.

Parents of children with disabilities have sought to reduce information barriers and to increase their participation in the care of their children (Laborde & Seligman, 1983; Seligman, 1979). Policies related to freedom of information and rights of parents of children with disabilities have evolved over many years (Turnbull & Turnbull, 1986). Similar provisions have begun to be considered for parents of children with chronic illnesses. For example, Meyer (1986) developed a special program for fathers and other family members called SEFAM, or Supporting Extended Family Members, which provided education, support, and involvement during evening hours for parents who work outside the home. The needs of parents of children with chronic illnesses for technical knowledge and practical information has begun to result in

recommendations for policies to be developed which address those needs (Hobbs et al., 1985; Pless & Perrin, 1985).

### Developmental Context

An important factor in the process of adjustment for children with disabilities and chronic illnesses is the developmental context of the child and the family. Issues related to the developmental level of the child at any given point, transitions across stages, and impact of the illness on life cycle of the family as a whole have been considered.

Developmentally appropriate expectations. Masters et al. (1983) maintained that "because children view their world very differently at different ages and stages of development, coping mechanisms will also vary with time" (p. 400). Whitt (1984) suggested that health care planning for children with chronic illnesses or disabling conditions take into account cognitive, emotional, and interpersonal assessment of development, as well as evaluations of stage specific vulnerabilities, e.g., abandonment, loss of control, bodily injury, loss of group approval, and self-concept distortions. Hobbs et al. (1985) maintained that developmental considerations should determine the manner and substance of medical disclosure which can be best understood by that child.

Level of development at onset may determine the ability of the child to establish certain self-management



skills and also affect decisions as to when responsibilities formerly assumed by parents can and should reasonably become the responsibility of the child (Johnson, 1986). Magrab and Calcagno (1978) also cautioned that concern for proper health care for the child be balanced with developmental need of the child for greater independence.

Life-long adaptation. The research of Olson, McCubbin, Barnes, Larsen, Muxen, and Wilson (1983) has identified the following basic stages in the family life cycle: couple, childbearing, school age, adolescence, launching, postparental, and aging. Each stage of development may require new adaptation for families of children with disabilities (Fewell, 1986; Foster & Berger, 1985). Seligman (1985) declared that, particularly for families with children with disabilities, adaptation is a life-long process.

Darling (1983) identified the following changing need stages of parents of children with disabilities: (a) prenatal, need for truthful diagnosis; (b) infancy, need for love, group support, services, advocacy; (c) childhood, need for realistic acceptance of disability; and (d) adolescence, need for support as accept adult limitations of children. Turnbull et al. (1986) identified stressors arising from developmental stages and transitions for

families with children with profound disabilities which extend into the aging years.

Issues related to movement through the family life cycle also have been considered for families of children with chronic illness. Duvall (1977) defined a family developmental task as "a growth responsibility that arises at a certain age in the life of a family, the successful achievement of which leads to present satisfaction, approval, and success with later tasks--whereas failure leads to unhappiness in the family, disapproval by society and difficulty with later family developmental tasks" (p. 167). Burr (1985) applied to families with children with chronic illness the eight family developmental task categories outlined by Duvall, i.e., physical maintenance, allocation of resources, division of labor, socialization of family members, maintenance and order, reproduction and recruitment, placement of family members in the larger society, and maintenance of morale. Rolland (1987a, 1987b) described the family as working through series of maintenance and developmental transition phases and cautioned that maintenance phases could be prolonged and developmental transitions become "derailed" as a result of the illness or disability. Drotar (1981) suggested that research designs allow for more data about how families of children with chronic physical conditions negotiate key developmental transitions.

### Attitudinal Differences among Counselors

Counselor bias occurs when clients are systematically offered services inappropriate for them or are denied services which are appropriate (Stricker & Shafron, 1983). Abramowitz and Murray (1983) described bias as occurring on three levels: (a) diagnostic assessments, (b) allocation and utilization of services, and (c) effectiveness of services. Both client characteristics and counselor characteristics have been considered as sources of bias in counseling.

### Client Characteristics

Client characteristics considered as sources of attitudinal differences among counselors have included gender, race, socioeconomic status, disability, and attractiveness. Although investigations of gender bias in counseling have eclipsed other bias research topics (Abramowitz & Murray, 1983), systematic patterns of gender bias (Stricker & Shafron, 1983) and racial bias (Abramowitz & Murray, 1983; Sattler, 1977) in counseling have not been documented empirically. Socioeconomic status (SES) has been found to be a more accurate predictor of counselor attitudes (Abramowitz & Doeckei, 1977). Sutton and Kessler (1986), in a national study of 242 clinical psychologists responding to case histories identical except for SES, found lower SES clients to have poorer prognoses, less interest in treatment, lower self concept, more severe

diagnoses, and in greater need of medications than those identified as middle and higher SES.

Biases toward persons with disabilities also have received attention. Tringo (1970) found a hierarchical pattern of preference toward categories of persons with disabilities, with persons with physical disabilities rated more positively followed in order by intellectual impairment, emotional disturbances, and social deviance. Goodyear (1983) found similar results in a study of 40 rehabilitation counselors who, using a semantic differential scale, rated persons with multiple orthopedic disabilities most favorably and, along with clients with mental retardation, as having good prognosis for rehabilitation; clients with schizophrenia and alcoholism were rated most negatively.

Other studies of attitudinal differences toward persons with disability have yielded contradictory findings. Martin, Scalia, Gay, and Wolfe (1982), in a study of 140 beginning rehabilitation counselors, found that male counselors expressed more positive attitudes toward persons without disabilities than toward those who had disabilities. Hopkins-Best (1987) found that secondary school counselors agreed that professional careers were more appropriate for students without disabilities than for students with hearing impairments or epilepsy. Bradshaw, Strohmer, and Biggs (1986), however, found that beginning

rehabilitation and counseling psychology students rated college students with and without disabilities no differently on a measure of attractiveness.

A related area of interest in research on counselor attitudes has been the role of client attractiveness in influencing counseling process and outcome. Counselors have expressed the so-called "YAVIS" preference for working with clients who are young, attractive, verbal, intelligent, and successful (Berger & Morrison, 1984; Mintz, 1982). Attraction between client and counselor has been associated with greater counselor interest and more frequent sessions (Hatfield & Perlmutter, 1983). Brown (1970) reported that clients who were judged as physically attractive, self-expressive, and likable also were more likely to be judged as having greater potential for change. Although medical personnel have been found to describe healthy children as more attractive than children with chronic conditions (Darling, 1979, 1983), there has been little research on the effects of client health conditions on counselor attitudes.

### Counselor Characteristics

Counselor characteristics considered in research on counselor attitudes include gender, race, level of experience, and theoretical orientation. Counselor gender has been found to be associated with level of counseling experience, with beginning trainee females more open and

variable than males and males adopting these characteristics with experience (Rice, Gurman, & Razin, 1974; Stricker & Shafran, 1983).

Counselor gender has also been found to interact with client characteristics. Hare-Mustin and Lamb (1984), in a study comparing male and female family and non-family counselors, found that males expressed more "traditional" attitudes toward women's roles than female counterparts on issues of abortion, male-female relations, maternal instinct, and women's control over reproduction. Martin, Scalia, Gay, and Wolfe (1982) found that males in beginning rehabilitation counseling programs were more likely than females to express less favorable attitudes toward persons with disabilities. Another study of gender differences, however, found male guidance counselors to be more positive than females about post-secondary aspirations of male and female high school students with and without disabilities (Hopkins-Best, 1987).

Studies in which the effects of level of counseling experience have been compared have had mixed results. Level of experience has been associated with counselor differences. Rice et al. (1974) found experienced counselors more interested in client history, more willing to wait for important material to emerge, more interpretive, more variable in their behaviors, and more revealing of themselves and their feelings. Inexperienced

counselors were more likely to report intensity of concern, attractiveness, potential for change, and personal liking for new clients than were more experienced counselors (Brown, 1970). Beginning rehabilitation counselors with prior counseling training, however, were found to be more positive toward clients with disabilities than were rehabilitation counselor trainees with no prior experience (Martin et al., 1982).

Other research on level of experience has found no support for differences. Sutton and Kessler (1986) found no significant results for level of experience in a national study of clinical psychologists' professional judgments toward clients from various socioeconomic groups. Elston and Snow (1986) found no differences in attitudes toward persons with disabilities based on educational level or experience with disability.

Effects of level of experience have been found to be associated with theoretical orientation (also referred to as style or specialty), and this association has been found to be confounded by historical changes (Auerbach & Johnson, 1977). For example, Prochaska and Norcross (1983) found less experienced counselors to be more involved in family counseling, a relatively new field of counseling practice.

In other research, theoretical orientation was found to differentiate among counselor attitudes more clearly than experience level (cf. Auerbach & Johnson, 1977).

Peterson and Bradley (1980) found that theoretical orientation rather than level of experience contributed to within group variance among behavioral, Gestalt, and rational-emotive counselors on measures of counseling attitudes. Bishop and Richards (1984) found that humanistic counselors were more likely to judge clients as more anxious and having more severe educational problems than were behavioral counselors. Hare-Mustin and Lamb (1984) found that non-family counselors were more traditional in their views toward abortion, male-female relations, and child-rearing abilities of working mothers than were family-oriented counselors.

#### Summary of the Related Literature

This review of the related literature has attempted to describe theoretical and empirical problems in "psychosomatic" illness research, coping models for families with chronic health conditions, and client and counselor variables which account for attitudinal differences among counselors. Theories related to both "psychosomatic" personalities and "psychosomatic" families have been criticized as based on questionable assumptions and lacking empirical support. These theories, however, have been assumed to continue to influence theory, research, and practice in mental health fields.

The incidence of chronic health conditions in children requires that health care providers consider the ways



families cope with these conditions over time. Of importance are personal-emotional strain, familial-social support, and contact with health care systems.

Certain client and counselor characteristics have been considered as sources of bias in counselor assessments and treatment of clients. While this review reflects a general lack of consistency in findings related to counselor bias toward specific groups, support was reported for bias toward clients based on perceived attractiveness and socioeconomic status.

### CHAPTER 3 METHODOLOGY

Investigated in this study were differences in counselors' ratings of family functioning on the bases of health condition of child and counselor specialty. Health status of child included bronchial asthma, idiopathic scoliosis, and no chronic illness or physical impairment. Counselor specialties included mental health counseling, marriage and family counseling, and school counseling. Counselors rated families on perceived levels of enmeshment, rigidity, and importance of factors known to reflect impact of health condition on the family.

#### Independent Variables

This study had two independent variables. One independent variable was health status of child, which consisted of three levels: bronchial asthma, idiopathic scoliosis, and no illness or disability. The two chronic conditions were chosen for conceptual reasons and representativeness of chronic illness and orthopedic disability.

Bronchial asthma is a chronic, reversible obstructive airways disease (Matus, 1981) found in approximately 5% of children in the United States under the age of 15 (Young,

1980). The most common period for the onset of bronchial asthma is between the ages of three to eight (Bronheim, 1978). This disease has been characterized as costly, disruptive, and potentially stressful to children and their families (Golbert, 1985; Kaplan & Sadock, 1985; Matus, 1981; Nieder, 1986; Stern, 1981; Young, 1980).

Bronchial asthma also has been described as the archetypical "psychosomatic" illness (Bronheim, 1978). While emotions do play a role, for example, laughing and crying have been found to trigger attacks in some individuals (Bronheim, 1978), the classic "psychosomatic" theories about children with asthma and their families have been found to lack empirical support (Bronheim, 1978; Golbert, 1985; Nieder, 1986).

Scoliosis is an orthopedic impairment of unknown causes, characterized by lateral curvature of the spine (Rangaswamy, 1983) which may result from congenital spinal anomalies, neuromuscular diseases, or from unknown or idiopathic causes. Idiopathic scoliosis is the most common form and has been classified according to the age of diagnosis: infantile (birth to three years of age), juvenile (four years old to puberty), and adolescent (Moe & Byrd, 1987). Infantile idiopathic scoliosis is uncommon in the United States. Juvenile idiopathic scoliosis accounts for 12% to 16% of total cases identified. Idiopathic

scoliosis is identified most often in adolescence when sudden growth makes spinal irregularities most pronounced.

Idiopathic scoliosis must be carefully monitored for signs of progression. School screening programs have been found to be important in early detection to reduce the severity of this condition. Modern treatment options include orthopedic braces, special seating, and corrective surgery.

The second independent variable was counselor specialty, which also consisted of three levels: mental health counseling, marriage and family counseling, and school counseling. Counselor specialty has been related to intake judgments (Bishop & Richardson, 1984), to counselor attitudes toward women's roles (Hare-Mustin & Lamb, 1984), and to counselors' theoretical attitudes and beliefs (Peterson & Bradley, 1980).

Mental health counseling has been described as provision of counseling services in the community, business or industry, or in private practice (Vacc & Loesch, 1987). Services provided may include counseling, preventive mental health programming, consultation, or vocational counseling and placement. For this study, a mental health counselor was someone trained in mental health counseling and employed as a mental health counseling professional. Counselors specializing in marriage and family counseling were treated separately.

Marriage and family counseling, an important emerging specialty in the counseling profession (Hollis & Wantz, 1986), focuses on the family as primary unit of change. While marriage and family theorists have tended to espouse "psychosomatic" theories of family dysfunctionality (cf. Dakof, 1987; Gurman et al., 1986), efforts have been made to promote psychoeducational approaches to helping families cope with biologically based problems (e.g., Coyne & Anderson, 1988, 1989; Johnson, 1987; Walsh & Anderson, 1988). For this study, a marriage and family counselor was someone trained as a marriage and family specialist and employed as a marriage and family counseling professional.

School counseling is a counseling profession specialty which focuses on the development of children and adolescents, and on interactions among children, school personnel, and parents (Vacc & Loesch, 1987). When children are identified as having special needs, school counselors are available to counsel them and/or to serve as consultants to school personnel and parents. In this study, a school counselor was someone trained in school counseling and employed as a school counseling professional.

#### Dependent Variables

Three dependent variables were investigated in this study: counselor's ratings of degrees of enmeshment, rigidity, and factors impacting families with chronic

conditions. Counselor ratings of enmeshment and rigidity represent the degree to which counselors view families as dysfunctional.

Minuchin et al. (1978) defined enmeshment as an extreme form of proximity and intensity in family interactions where "changes within one family member or in the relationship between two members reverberate throughout the system" (p. 30). On the Clinical Rating Scale (CRS) for the Circumplex Model of Marital and Family Systems (Olson, 1988b), the enmeshed family is characterized as having extreme family closeness and involvement, where little time and space alone are permitted, and where joint family activities predominate.

Rigidity was defined by Minuchin et al. (1978) as an insistence on retaining the accustomed methods of interaction so that the family is "highly vulnerable to external events" (p. 31). On the CRS (Olson, 1988b), rigid families are characterized as having strict rules and consequences, limited negotiations, and very defined family roles.

Counselor rating of impact on the family is the degree of importance counselors ascribe to factors which describe the impact of the illness on these families. These factors, derived from a longitudinal study of families of children with chronic illness (Stein & Reissman, 1980),

include (a) personal strain, (b) familial/social impact, (c) financial burden, and (d) sense of mastery.

### Population

The population for this study consisted of members of the Florida Association for Counseling and Development (FACD). FACD is one of the 56 state and international branches of the American Association for Counseling and Development (AACD). Membership in FACD (and in AACD) is limited to persons whose primary responsibilities or interests are in the areas of counseling and human development, including those persons who work in schools, colleges, mental health agencies, rehabilitation facilities, community agencies, business/industry, private practice, employment and related human service settings, and students who are engaged more than half-time in studies in counseling and/or human services areas.

AACD has over 55,000 members currently (American Association for Counseling and Development, 1989), including approximately 65% females and 35% males. Approximately 93% of the members are White, 4% are Black, 1% are of Hispanic origin, and 2% are of other origins. The average member is between 39 and 48 years of age and holds a Master's degree. Approximately 74% of the total are professional members, 22% are student members, and 4% are retired or other. Approximately 25% of AACD members work in school settings, 25% in college and university

settings, 25% in agency, correctional, governmental, and business settings, and 25% in private practices. The Florida Association for Counseling and Development has membership of almost 3,000 currently. Membership categories are essentially the same as those for AACD, although school counselors are slightly overrepresented.

### Sampling Procedures

The sample for this study was drawn from among professional mental health, marriage and family, and school counselors attending the 1989 FACD Annual Convention and non-attending members contacted following the convention. Potential attendees were identified from the convention registration list from the preceding year and were contacted by mail (Appendix A) prior to the convention. Those agreeing to participate were asked to complete a demographic questionnaire. Demographic data collected included pre-service counselor training information, current employment setting, and gender.

The initial objective was to obtain a sample of 15 male and 15 female professional counselor subjects from each of three counseling specialties (i.e., mental health counseling, marriage and family counseling, and school counseling), for a minimum of 90 counselors. When responses to the pre-convention letter did not result in the minimum, a request for research subjects also was given to on-site registrants.



Because the minimum sample of subjects (90) was not obtained at the FACD Annual Convention, two additional procedures were used: (a) subjects who had agreed to participate but who had not done so during the FACD Convention were contacted and (b) subjects were sought from among FACD members not attending the Convention. Similar sampling procedures were followed for the subjects not attending the Convention. However, they were asked to complete data collection at four locations across the state.

As an administrative convenience, all who wished to participate were allowed to complete data collection, but only data from subjects who met the criteria of their counseling specialty were included in subsequent analyses. Information from the Demographic Data Sheet provided the basis for inclusion or exclusion in the remainder of the study. One hundred nineteen counselors agreed to participate. Eleven were excluded because of dual employment which included two counseling specialties, less than a minimum of two years experience, or less than a master's educational level. Four subjects failed to complete all instruments.

The resultant sample of 104 subjects included 30 Mental Health Counselors, 33 Marriage and Family Counselors, and 41 School Counselors. Forty-seven males and 57 females were included. Ethnic groups were

represented as follows: 1 Black, 4 persons of Hispanic decent, 97 Whites, and 2 other. Subjects ranged in age from 25 to 63, with an average age of 43. Educational levels represented included 62 master's degrees, 26 educational specialist degrees, and 16 doctorates.

The 30 Mental Health Counselors who participated in this study had from 2 to 20 years of experience in counseling with an average of 7.3 years. Mental Health Counselors indicated they had completed from 0 to 8 courses related to family counseling, averaging 1.8 classes per person.

The 33 Marriage and Family Counselors who participated listed from 2 to 32 years of experience counseling families, with an average of 8.9 years. They had completed 0 to 10 family counseling courses, with an average of 4.7 courses.

The 41 School Counselors who were included in this study had worked from 2 to 30 years as school counselors, with an average of 10.7 years. They had completed 0 to 5 family counseling courses with an average of .9 courses per person.

#### Research Design

This study used two factorial designs. The first, a 3 X 3 factorial design, was used to obtain counselor ratings of enmeshment and rigidity. The first factor (independent variable), health condition of child, consisted of three

levels: bronchial asthma, congenital scoliosis, and no chronic illness or physical impairment. The second factor, counselor specialty, consisted of three levels: mental health counseling, marriage and family counseling, and school counseling. The revised Clinical Rating Scale (CRS) for the Circumplex Model of Marital and Family Systems (Olson, 1988b) was used to assess counselor ratings of enmeshment and rigidity.

The 3 X 3 factorial design is depicted as follows:

<u>Counselor Specialty</u>	<u>Health Status of Child</u>		
	<u>Asthma</u>	<u>Scoliosis</u>	<u>No Condition</u>
Mental Health			
Marriage and Family			
School			

Figure 3-1. Experimental 3 X 3 design.

The second design, a 2 X 3 factorial, was used to analyze counselor ratings of importance of impact of chronic conditions on family. The first independent variable, health condition, consisted of two levels: bronchial asthma and congenital scoliosis. No illness or disability was included in this design. The second factor,

counselor specialty, consisted of three levels: mental health counseling, marriage and family counseling, and school counseling. The Modified Impact-on-Family Scale was used to assess counselor ratings of the importance of factors known to impact families of children with chronic health conditions. The modification was endorsed by the author (R. E. K. Stein, personal communication, 1989).

Health Status of Child		
<u>Counselor Specialty</u>	Asthma	Scoliosis
Mental Health		
Marriage and Family		
School		

Figure 3-2. Experimental 2 X 3 design.

### Experimental Procedures

Counselors from each of the three counselor specialty groups were randomly assigned to three health condition groups. All three groups of counselors were shown the same videotaped interview and received similar biographical information about the family. The biographical information about the family differed only on one point: health status of a child in the family. Subjects in Group 1 were informed that the older child in the family had bronchial

asthma and that the younger child was in good physical condition. Those in Group 2 were informed that the older child in the family had scoliosis and the younger child was in good physical condition. Group 3 subjects were told that both children in the family were in good physical condition.

A semistructured interview of an actual intact family was videotaped for use in this study. The family was a dual-earner family with two children. One child was elementary school-aged, and identified as having problems adjusting to a new school. The interviewer was a doctoral student from a program in the University of Florida Counselor Education Department.

The format of the interview followed instructions for use of the revised Clinical Rating Scale (Olson, 1988b), in which the following was suggested:

Although no specific clinical techniques or format are recommended for the interview, we have found it useful to encourage the couple or family to dialogue with each other regarding how they handle these general issues, that is, time, space, discipline, etc. Asking the family to describe what a typical week is like and how they handle their daily routines, decision making, and conflict is often illuminating. (p. 2)

In order to provide information relevant to the Impact-on-Family Scale, the family also was asked general questions about health issues, for example: How do you manage doctor visits for the children? Who usually takes off work? How do you manage days when the children are too

sick to go to school or the sitter? Are there family or friends you can call to help? The interviewer did not probe into or mention specific kinds of illnesses or conditions experienced by the family.

After completion of the interview, the videotape was shown to a group of counseling trainees. From this pilot study a determination was made that subjects were able to respond to instructions based on information provided on the videotape.

### Assessment Instruments

The dependent variables (i.e., counselors' ratings of enmeshment and rigidity) were assessed with the revised Clinical Rating Scale (CRS) for the Circumplex Model of Marital and Family Systems (Olson, 1988b). The dependent variable (i.e., counselors' ratings) of impact on the family was assessed with a modification of the Stein and Reissman (1978) Impact-on-Family Scale (R. E. K. Stein, personal communication, 1989).

#### Clinical Rating Scale

The revised Clinical Rating Scale (CRS) for the Circumplex Model of Marital and Family Systems (Olson, 1988b) is a counselor-scored assessment instrument which allows for ratings of three factors, or dimensions, of family behavior: (a) cohesion, (b) adaptability, and (c) communication. The communication dimension was developed independent of, and never formally integrated into, the

Circumplex Model (Grotevant & Carlson, 1989) and was not used in this study.

A videotaped, semistructured interview is the format suggested for the assessment of families in using the CRS. Encouraging families to dialogue with each other regarding general issues (e.g., in regard to time, space, discipline, routines, decision making, and conflict) is recommended.

Six subscales contribute to a Global Cohesion Rating: (a) emotional bonding, (b) family involvement, (c) marital relationship, (d) parent-child coalitions, (e) internal boundaries, and (f) external boundaries. Cohesion subscales are scored 1 for Disengaged, 2 for Separated, 3 for Connected, and 4 for Enmeshed. Raters are encouraged to base the Global Cohesion Rating, also scored 1 for Disengaged, 2 for Separated, 3 for Connected, and 4 for Enmeshed, on "overall evaluation, not on a [mere] sum score of the subscales" (Olson, 1988b, p. 6).

Five subscales contribute to a Global Adaptability Rating: (a) leadership, (b) discipline, (c) negotiation, (d) roles, and (e) rules. Adaptability subscales are scored 1 for Rigid, 2 for Structured, 3 for Flexible, and 4 for Chaotic. Raters are encouraged, as on the Cohesion scale, to base the Global Adaptability Rating, scored 1 for Disengaged, 2 for Separated, 3 for Connected, and 4 for Enmeshed, on overall evaluation.

Olson (1988a) reported that, using five raters on a sample of 45 families, the average interrater correlation was .88 for Cohesion and .84 for Adaptability. These correlations are comparable to interrater correlations reported for the McMaster Clinical Rating Scale (Epstein, Baldwin, & Bishop, 1983) which ranged from .57 to .91 for subscales. In a critique of observational family rating scales, Fisher (1987) found the Olson and McMaster scales to exhibit adequate reliability, whereas other scales reviewed were found to exhibit borderline reliabilities.

Validity for the CRS has not been established empirically (Grotevant & Carolson, 1989). For this study, however, the CRS did have face validity. The terms "enmeshed" and "rigid" appeared on the rating form, and behaviors describing these terms appeared consistent with characteristics described by Minuchin et al. (1978) in the "psychosomatic family" study.

The CRS, therefore, exhibited both face validity and adequate interrater reliabilities for the purposes of this study. Face validity is an important factor in allowing responses based on possible bias (Sax, 1980). Moreover, interrater reliabilities for the CRS are among the highest for instruments of this type and served to reduce error variance based on individual rating differences.



### The Modified Impact-on-Family Scale

The Modified Impact-on-Family Scale (MIFS) is a 24-item, factor-based scale modified to assess counselors' ratings of the importance of factors found to reflect the impact of a child's chronic illness on the family, including (a) financial burden, (b) familial/social impact, (c) personal strain, and (d) sense of mastery. Financial burden relates to the economic consequences for the family of the presence of an ill child. Familial/social impact relates to the disruption in normal social interaction both within and outside the family system which is a direct consequence of a child's illness. Personal strain, which is related to familial/social impact, relates to the personal disequilibrium experienced by the primary caretaker of the ill child. Mastery, relatively independent of the other factors, relates to the coping strategies employed by the family to master the stress of the illness.

The Impact-on-Family Scale (IFS), developed by Stein and Reissman (1978) during a longitudinal study of families of children with chronic illnesses, is a self-report measure of factors influencing coping among these families. From a pool of 190 items, a panel of experts chose 58 items for clarity of expression, face validity, appropriateness for the construct being measured, and potential for differentiating the target population. Thirty-two of the

58 items were retained following in-depth interviews and assessment of families of children with chronic illnesses. These 32 items were administered (Stein & Reissman, 1980) to 100 parents of children with chronic illnesses. Factor analysis resulted in 8 items being deleted as a result of low factor loadings or significant missing data.

Internal consistency reliability of the IFS was computed using Cronbach's coefficient alpha (Stein & Reissman, 1980). The reliability coefficient for the total scale was .88. Reliabilities for subscales were .72 for financial, .86 for familial/social, .81 for personal strain, and .60 for mastery.

Validity for the IFS for families with chronic illness has been examined. Impact-on-family factors have been found to be related to functional status of the child, maternal distress, and personal and financial resources of the family (Jessop, Reissman, & Stein, 1988; McCormick, Charney, & Stemmler, 1986; Stein & Jessop, 1984).

Although not established empirically, use of the IFS for assessing the impact of disability on the family has been suggested. In a review of assessment instruments for families and children with disabilities, Mott, Fewell, Lewis, Meisels, Shonkoff, and Simeonsson (1986) identified the IFS, with minor modifications, as a primary assessment instrument for families of children with disabilities.

### Research Procedures

Demographic information was collected from subjects who participated in this study. Demographic information included counselor training (i.e., preservice information), current employment setting, and gender.

From demographic information on training and work setting, subjects were identified by specialty (i.e., mental health, marriage and family, and school counseling). Male and female subjects from the three specialties were randomly assigned to three groups and given biographical sketches prior to viewing the videotape. Subjects in Group 1 were given a biographical sketch (Appendix B) of a family which described a child in the family with bronchial asthma. Subjects in Group 2 were given a biographical sketch of a family which described a child in the family with idiopathic scoliosis. Subjects in Group 3 were given a biographical sketch of a family which described children in the family in good physical condition, with no mention of illness or physical disability. The remainder of the biographical sketch was the same for all groups.

Groups 1, 2, and 3 received copies of the revised Clinical Rating Scale (Olson, 1988b), with printed instructions for use of the scale. Subjects were asked to rate a 20-minute videotaped family interview using the CRS. Subjects from Group 3 were dismissed upon completion of the Clinical Rating Scale.

Subjects from Groups 1 and 2 also were asked to complete the Modified Impact-on-Family Scale (R. E. K. Stein, personal communication, 1989). The Impact-on-Family Scale (Stein & Reissman, 1978) was modified to refer to chronic condition rather than illness (cf. Mott, Fewell, Lewis, Meisels, Shonkoff, & Simeonsson, 1986) and to reflect counselor assessment of impact.

### Hypotheses

Counselor ratings of enmeshment, rigidity, and impact on the family were evaluated as a function of health status of child and counselor specialty. The following null hypotheses were investigated:

- HO<sub>1</sub>: There is no difference in counselors' ratings of familial enmeshment as a function of child's health condition.
- HO<sub>2</sub>: There is no difference in counselors' ratings of familial enmeshment as a function of counseling specialty area.
- HO<sub>3</sub>: There is no effect for familial enmeshment ratings due to interaction of counseling specialty areas and child's health condition.
- HO<sub>4</sub>: There is no difference in counselors' ratings of familial rigidity as a function of a child's health condition.

- HO<sub>5</sub>: There is no difference in counselors' ratings of familial rigidity as a function of counseling specialty area.
- HO<sub>6</sub>: There is no effect on familial rigidity ratings due to interaction of counseling specialty area and child's health condition.
- HO<sub>7</sub>: There is no difference in counselors' ratings of impact of chronic condition as a function of child's health condition.
- HO<sub>8</sub>: There is no difference in counselors' ratings of impact on family as a function of counseling specialty area.
- HO<sub>9</sub>: There is no effect on ratings of impact on chronic condition due to interaction of counseling specialty areas and child's health condition.

#### Data Analyses

The data analyses conducted in this study were factorial analyses of variance. Using scale scores for counselor ratings of enmeshment and rigidity, two-way analyses of variance were performed to determine significances of differences among the groups for the independent variables of health status of child (i.e., bronchial asthma, idiopathic scoliosis, and no illness or physical disability) and specialty of counselor (i.e., mental health counseling, marriage and family counseling, and school counseling). Main effects (i.e., health status

of child or counselor specialty) as well as two-way interactions (i.e., health status of child by counselor specialty) also were investigated. Because enmeshment and rigidity have been derived from subscales of the same instrument, a (Bonferroni corrected) confidence level of  $p < .025$  was used.

Using scale scores for counselor ratings of impact on the family, two two-way analyses of variance were performed to determine significances of differences among groups for the independent variables of health status of child and specialty of counselor. Main effects (i.e., health status of child or counselor specialty) as well as two-way interactions (i.e., health status of child by counselor specialty) were investigated. A confidence level of  $p < .05$  was used for statistical significance.

#### Methodological Limitations

This study was designed to address issues of internal and external validity through random assignment of conditions, use of a control group, and standardized treatment procedures. Potential rival hypotheses (e.g., counselor gender and level of experience) were included and examined in the research design.

Ecological validity may be threatened if subjects rate families differently because of experimental conditions. Suggested by the so-called "Hawthorne effect" is that research subjects behave differently as a consequence of

demand characteristics, evaluation apprehension, and social desirability (Huck, Cormier, & Bounds, 1974). In this study, this potential effect was limited by random assignment of conditions and anonymity of subject responses.

There are many factors which affect the evaluations counselors might make of counseling activities, including characteristics of subjects, counseling procedures used, evident outcomes, and characteristics of counselors. Only the first of these was specifically addressed in this study. However, the methodology was constructed so as to limit the impacts of other factors which could influence the evaluations made. Therefore, although a variety of factors might have influenced the data obtained, care was used to restrict the influences of other factors.

## CHAPTER 4

### RESULTS

The purpose of this study was to investigate whether subjects grouped by two independent variables (health status of child and counselor specialty) significantly differed on three dependent variables (enmeshment, rigidity, and impact on family) reflecting perceived degree of family dysfunction and demands placed on the family of a child with a chronic health condition.

One hundred four subjects participated in this study, with all providing data on enmeshment and rigidity. Seventy-two subjects provided data on impact of chronic condition on the family; 32 control (no chronic condition) subjects did not provide impact on the family data. Data analyses were conducted as described in Chapter 3.

#### Enmeshment and Rigidity

Analyses of variance on enmeshment and rigidity scores derived from the cohesion and adaptability subscales of the Clinical Rating Scale yielded no significant main effects for health status of child or counselor specialty. The interaction effect of health status of child and counselor specialty also was not significant. Shown in Table 4-1 are the results of these analyses of variance as well as the



Table 4-1

Means and Standard Deviations for Enmeshment Subscale Scores on Counselor Rating Scale with ANOVA Statistics for Groups by Health Status of Child, Counselor Specialty, and Health Status of Child and Counselor Specialty

Health Status of Child	M	SD	ANOVA Statistics
Bronchial Asthma (n=35)	2.57	.40	$F = 1.49$
Idiopathic Scoliosis (n=37)	2.73	.45	$df = 2/95$
No Chronic Condition (n=32)	2.75	.44	$p < .23$
Counselor Specialty			
Mental Health (n=30)	2.60	.50	$F = .67$
Marriage and Family (n=33)	2.73	.45	$df = 2/95$
School (n=41)	2.71	.46	$p < .51$
Health Status of Child and Counselor Specialty			
Bronchial Asthma and Mental Health (n=10)	2.40	.52	$F = .51$
Bronchial Asthma and Marriage and Family (n=10)	2.70	.48	$df = 4/95$
Bronchial Asthma and School (n=15)	2.60	.51	$p < .73$
Idiopathic Scoliosis and Mental Health (n=10)	2.60	.52	
Idiopathic Scoliosis and Marriage and Family (n=13)	2.77	.44	
Idiopathic Scoliosis and School (n=14)	2.78	.43	
No Chronic Condition and Mental Health (n=10)	2.80	.42	
No Chronic Condition and Marriage and Family (n=10)	2.70	.48	
No Chronic Condition and School (n=12)	2.75	.45	

means and standard deviations for enmeshment scores on the Clinical Rating Scale for health status of child, counselor specialty, and health status of child and counselor specialty. Shown in Table 4-2 are the results of the analyses of variance as well as the means and standard deviations for rigidity scores on the Clinical Rating Scale for health status of child, counselor specialty, and health status of child and counselor specialty.

#### Impact on Family

Analyses of variance on the overall score on the Modified Impact-on-Family Scale yielded no significant main effects by health status of child or counselor specialty. The interaction effect of health status of child and counselor specialty also was not significant. Shown in Table 4-3 are the results of the analyses of variance as well as means and standard deviations for impact on family scores on the Modified Impact-on-Family Scale.

Table 4-2

Means and Standard Deviations for Rigidity Subscale Scores on Counselor Rating Scale with ANOVA Statistics for Groups by Health Status of Child, Counselor Specialty, and Health Status of Child and Counselor Specialty

Health Status of Child	M	SD	ANOVA Statistics
Bronchial Asthma (n=35)	2.51	.56	$F = .62$
Idiopathic Scoliosis (n=37)	2.37	.49	$df = 2/95$
No Chronic Condition (n=32)	2.43	.50	$p < .54$
Counselor Specialty			
Mental Health (n=30)	2.33	.48	$F = 1.33$
Marriage and Family (n=33)	2.42	.50	$df = 2/95$
School (n=41)	2.54	.55	$p < .27$
Health Status of Child and Counselor Specialty			
Bronchial Asthma and Mental Health (n=10)	2.50	.53	$F = 1.08$
Bronchial Asthma and Marriage and Family (n=10)	2.60	.52	$df = 4/95$
Bronchial Asthma and School (n=15)	2.60	.51	$p < .37$
Idiopathic Scoliosis and Mental Health (n=10)	2.10	.32	
Idiopathic Scoliosis and Marriage and Family (n=13)	2.38	.51	
Idiopathic Scoliosis and School (n=14)	2.57	.51	
No Chronic Condition and Mental Health (n=10)	2.40	.52	
No Chronic Condition and Marriage and Family (n=10)	2.30	.48	
No Chronic Condition and School (n=12)	2.75	.45	

Table 4-3

Means and Standard Deviations for Impact on Family Scores on Modified Impact-on-Family Scale with ANOVA Statistics for Groups by Health Status of Child, Counselor Specialty, and Health Status of Child and Counselor Specialty

Health Status of Child	M	SD	ANOVA Statistics
Bronchial Asthma (n=35)	42.31	6.97	$F = 1.07$
Idiopathic Scoliosis (n=37)	40.21	10.08	$df = 1/66$
			$p < .30$
Counselor Specialty			
Mental Health (n=20)	43.35	10.19	$F = .82$
Marriage and Family (n=23)	40.39	5.64	$df = 2/66$
School (n=29)	40.45	9.61	$p < .45$
Health Status of Child and Counselor Specialty			
Bronchial Asthma and Mental Health (n=10)	43.90	7.00	$F = 2.19$
Bronchial Asthma and Marriage and Family (n=10)	38.60	5.87	$df = 2/66$
Bronchial Asthma and School (n=15)	43.73	7.11	$p < .12$
Idiopathic Scoliosis and Mental Health (n=10)	42.80	13.03	
Idiopathic Scoliosis and Marriage and Family (n=13)	41.77	5.26	
Idiopathic Scoliosis and School (n=14)	36.93	10.90	

## CHAPTER 5 DISCUSSION

The importance of counselors' assessments of family characteristics when a child has a chronic health condition (i.e., chronic illness or permanent physical disability) has been emphasized in the literature as critical to outcomes of counseling. Concern has been voiced that because theoretical and methodological problems plague much of the literature on families of children with chronic illnesses, counselors' assessments of those families may reflect the bias that these families are inherently dysfunctional.

One of the most influential, and challenged, sources of opinions on family dysfunction associated with chronic illness of a child postulated that family characteristics (i.e., enmeshment, rigidity, overprotectiveness, conflict avoidance, and involvement of the child in marital conflicts) aided in the development and maintenance of certain chronic illnesses. Two of those characteristics, family enmeshment and rigidity, were examined in this study.

The literature on counseling families of children with physical disabilities has de-emphasized dysfunctionality

and focused on family coping with the impact of the chronic health condition. Because chronic illnesses and physical disabilities may impact families similarly, this study included counselors' assessments of the impact of chronic conditions on families of children with physical disabilities and chronic illnesses.

Three groups of counselors, representing three counseling specialties, could be expected to provide services to members of families when a child has a chronic health condition. Those specialties which were represented in this study, are mental health counseling, marriage and family counseling, and school counseling.

#### Limitations

There are certain factors which limit the generalizability of the findings of the present study. Of major significance is that subjects chosen reflected an experimentally accessible population of counselors from a single state. Those subjects, however, were not substantively dissimilar from a national organization of professional counselors on characteristics of age, level of education, ethnic representativeness, and membership eligibility. In addition, although subjects were not randomly selected, treatment assignments were randomized.

Although subjects in this study were differentiated by work setting and self-identification of counseling specialty, discrimination among the three counselor groups

based on counselor training--specifically family counseling training--could not be made. Although not identifying themselves as family counselors, most mental health and school counselors in this study reported having received family counseling training. Some training overlap, therefore, existed among counseling groups.

Another limitation for this study involved use of volunteers. Volunteers may have responded differently than non-volunteers. For example, the degree to which subjects may have responded in a socially desirable manner is unknown.

A videotaped, semistructured interview format was used in this study rather than live clients. Although Olson (1988a) reported high interrater reliability for counselor ratings of semistructured interviews, the degree to which these ratings approximate assessments made from live, interactive interviews is a factor in determining generalizability.

#### Evaluation of Hypotheses

As evidenced by the data, no support for rejection of for  $H_{O1}$  through  $H_{O8}$  was found in this study. No differences were found in counselors' ratings of enmeshment based on child's health status (bronchial asthma, idiopathic scoliosis, no chronic condition) or counselors' specialty (mental health, marriage and family, school), and

no interaction effect for enmeshment between child's health status and counselors' specialty was noted.

The null hypotheses were also not rejected for counselors' ratings of rigidity based on child's health status or counselors' specialty. No interaction effects for rigidity were noted for rigidity between health status of child and counselors' specialty.

Similarly, the data supported the null hypotheses of no difference in counselors' ratings of impact of chronic condition on the family based on health status of the child and counselors' specialty. No interaction effect for impact of chronic condition on the family was found between health status of child and counselors' specialty.

In this study, therefore, for the manipulated variable of health status of child, counselors from three specialties rated families no differently across three measures. Counselors' ratings of families also did not differ on the basis of health conditions of a child in the family nor on the basis of counselors' specialties.

### Conclusions

Despite the limitations of the findings, certain conclusions may be drawn in regard to the hypotheses proposed. Within the context of this study, counselors did not, in response to stimuli from a videotaped, semistructured interview with a family, exhibit bias toward a family based on what they were told about the health



status of a child in the family. The absence of significant indications of counselor bias toward families of children with chronic health conditions in the study in turn suggests several possibilities. Perhaps "psychosomatic" literature has not been, or is no longer, as influential to theories about and practice with families with chronic health conditions as supposed (cf. Bloom, 1988; Creer, 1982; Dakof, 1987; Gurman et al., 1986). An alternative explanation is that the counselors may have been influenced either by recent attempts in the literature to challenge "psychosomatic" theory (Coyne & Anderson, 1988, 1989) or by information about psychoeducational approaches to understanding the impact of chronic conditions on families (e.g., Gonzalez, Steinglass, & Reiss, 1989; Hobbs et al., 1985; Johnson, 1987; Masters et al., 1983; McCubbin et al., 1979; Stein & Reissman, 1980).

The results of this study may reflect the general lack of consistency in findings related to counseling bias toward specific groups of clients (cf. Abramowitz & Murray, 1983; Stricker & Shafron, 1983) and among specific groups of counselors (cf. Hopkins-Best, 1987; Martin et al., 1982). It is possible that counselors are aware of and able to avoid more overt sources of bias toward specific groups than more subtle characteristics of clients, e.g., perceived attractiveness and socioeconomic status (Mintz, 1982; Sutton & Kessler, 1986).

### Implications

Considering the data from this study, a number of implications are apparent. These implications apply to areas of counseling theory, research, training, and practice.

Because no differences were found across health conditions, caution should be used in accepting "psychosomatic" theories of family dysfunction while efforts are continued to expand theories of family coping with chronic health conditions. Despite the fact that 1 in 10 children are predicted to experience a chronic health condition during childhood (Magrab & Calcagno, 1978), Dakof (1987) maintained that theories of family and health issues "remain at the starting gate" (p. 135). Accordingly, better interdisciplinary theories drawn from medical, educational, and mental health fields are needed to expand the understanding of impact of chronic health conditions and families' needs for mastery and coping across the lifespan. Concomitantly, such theories should avoid inclusion of psychosomatic theories of family dysfunction.

In this study counselors did not evaluate families differently based on health status of a family member. However, researchers should consider other potential sources of bias, e.g., quality, availability, and outcome of services (cf. Abramowitz & Murray, 1983), which influence their judgments. Much remains to be learned

about how families cope most effectively with personal stressors, needs for family and social support, contacts with health care systems, need for education and mastery, and developmental changes across the lifespan (cf. McCubbin et al., 1979; Stein & Reissman, 1980).

Counselor training programs should continue to educate students to recognize sources of bias toward chronic and "psychosomatic" conditions. Counselor trainees also should be educated about the potential among interdisciplinary theories for new approaches to understanding the needs of families with special health concerns.

While counselors participating in this study did not associate chronic health conditions with dysfunctional family patterns on ratings drawn from videotaped interviews, practitioners should be encouraged to consider other potential sources of bias. Of particular importance is lack of identification of families with special health concerns as well as problems related to availability and effectiveness of services for those families.

#### Recommendations

Based on the results of this study, recommendations for further research are warranted. The following studies are suggested for research in the area of counselors' assessment of families of children with chronic health conditions.

1. The current study should be replicated with beginning counseling students to evaluate the influences of different aspects of training on assessment of families of children with chronic health conditions.

2. The association between counselors' knowledge of chronic conditions and assessment of families also should be investigated among counseling practitioners.

3. Subscales of the Modified Impact-on-Family Scale could, and should, be used to measure counselors' perceptions of the importance of personal stress, social support, financial strain, and sense of mastery for families of children with chronic health conditions.

4. Other assessment instruments should be used to determine counselors' plans for treatment and prognoses for outcomes for families of children with chronic health conditions.

5. Differences between assessments made from live interactions as opposed to videotaped semistructured interviews, i.e., assessments of persons conducting interviews should be compared to responses of subjects watching videotape only.

6. The manner and degree to which family health care concerns should be addressed in the counseling process should be investigated among counseling practitioners.

### Summary

Although recommendations for (family) counseling practice continue to be made based upon the relatively highly criticized theories of "psychosomatic personalities" and/or "psychosomatic families," little is known of the extent to which practicing counselors actually apply these theories. Therefore, investigated in this study were differences in counselors' ratings of family enmeshment, rigidity, and impact of chronic condition on the family as functions of (a) the health status of a child in the family and (b) counselor specialty.

Indicated in the results of this study was that counselors' ratings of family enmeshment, rigidity, and impact of chronic condition on the family did not differ (a) according to whether the child in the family was identified as having bronchial asthma, idiopathic scoliosis, or good health with no mention of chronic conditions, or (b) according to whether the counselor specialized in mental health, marriage and family, or school counseling.

In future studies researchers may address replication of the procedures with different populations, with additional dependent variables, or with live interviews compared to videotaped family interviews.

APPENDIX A  
LETTERS TO COUNSELORS AND  
COUNSELOR INFORMATION FORM

October 18, 1989

Dear FACD Member:

I will be conducting a **Family Research Project** at the FACD Convention in Orlando, November 16-18, and would like to invite you to participate. The purpose of the project is to assess professional counselors' evaluations of certain family dynamics.

Participation would involve (a) completing and returning the attached information sheet, (b) taking approximately 20 minutes during the convention to view a videotape of a family counseling session, and (c) completing three brief questionnaires requiring approximately 20 minutes of your time.

Check in for the Family Research Project will be adjacent to the Membership Booth in the **Exhibits Area**. The project will run continuously during the Convention every hour on the hour as follows:

**Thursday, November 16 - 1:00 p.m. - 9:00 p.m.**

**Friday, November 17 - 8:00 a.m. - 9:00 p.m.**

**Saturday, November 18 - 8:00 a.m. - 11:00 a.m.**

Thank you for considering participation in the Family Research Project. Please contact me if you have any questions. I look forward to hearing from you.

Sincerely,

Mickie Miller, Ed.S.  
1215 Norman Hall  
University of Florida  
Gainesville, FL 32611  
Evenings: 904-371-6786  
Mornings: 904-392-0731

Dear

Thank you for volunteering for the Family Research Project.  
We will meet \_\_\_\_\_.

Enclosed are copies of the counselor information form for the study. I need mental health counselors and marriage and family counselors who hold graduate degrees and have at least two years experience in counseling-related employment. Participants need not be licensed or certified.

I will need about 40 minutes for the actual project plus a few minutes to say hello and answer questions. Participants will view a 20 minute video and complete two evaluations which take about 20 minutes. Please have the enclosed counselor information form completed prior to the meeting.

I look forward to seeing you and am very pleased that you can participate in this study.

Sincerely,

Mickie Miller  
1215 Norman Hall  
University of Florida  
Gainesville, Fl 32611  
(904) 392-0731



## COUNSELOR INFORMATION

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_

\_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ETHNIC GROUP: Black \_\_\_\_\_  
 Hispanic \_\_\_\_\_  
 Asian \_\_\_\_\_  
 White \_\_\_\_\_  
 Other \_\_\_\_\_

## EDUCATION

Your highest degree: \_\_\_\_\_

Indicate your counseling  
training specialty:

\_\_\_\_\_ Mental Health  
 \_\_\_\_\_ School  
 \_\_\_\_\_ Marriage & Family  
 \_\_\_\_\_ Other \_\_\_\_\_

Indicate number of courses  
in each of the following  
areas:

\_\_\_\_\_ Mental Health  
 \_\_\_\_\_ School  
 \_\_\_\_\_ Marriage & Family

## EMPLOYMENT

Indicate your current counseling  
employment specialty:

\_\_\_\_\_ Mental Health  
 \_\_\_\_\_ School  
 \_\_\_\_\_ Marriage & Family  
 \_\_\_\_\_ Other \_\_\_\_\_

Indicate years of  
experience in each of  
the following areas:

\_\_\_\_\_ Mental Health  
 \_\_\_\_\_ School  
 \_\_\_\_\_ Marriage & Family

Please return to:

Mickie Miller  
 1215 Norman Hall  
 University of Florida  
 Gainesville, Florida 32611

APPENDIX B  
INFORMED CONSENT FORM AND  
FAMILY PROFILE

## FAMILY RESEARCH PROJECT

### Informed Consent Form

The purpose of this research is to assess professional counselors' evaluations of certain family dynamics. Your participation in this study would involve:

1. Completing a counselor information sheet
2. Viewing a 20 minute videotape of a family counseling session
3. Completing three questionnaires (requiring approximately 20 minutes total)

No risks are anticipated, nor is any immediate benefit for you expected. In addition, no monetary compensation for participation will be provided.

This investigation is to be used for educational purposes, which may include publication of aggregate data. You may withdraw from consent and participation at any time without prejudice.

The information derived for this study will be kept confidential. Upon receipt of demographic information, coded data will be entered into a computer without specifically identifying information and response sheets destroyed.

\*\*\*\*\*

I have read and I understand the procedure described above. I agree to participate in the procedure and I have received a copy of this description.

Signed \_\_\_\_\_

Date \_\_\_\_\_

I have defined and explained fully this research to the participant whose signature appears above.

Signed \_\_\_\_\_

Rose "Mickie" Miller  
Ph.D. Candidate  
University of Florida  
1215 Norman Hall  
Gainesville, FL 32611  
(904) 392-0731

## FAMILY PROFILE

Greg and Candy have been married for 11 years. They have two children, Amber and Kristin.

Greg, who is 37 years old, works as lead mechanic for a regional transit system. He is the middle son in a family of three boys. Greg's mother has been dead for five years. His father died during the Christmas holidays this past year after a long battle with cancer.

Candy, age 36, works as a secretary for the state. As the older of two daughters, she spent her school years in the western portion of the country, moving to Florida as a teenager. Her parents and sister currently reside on the west coast.

This summer Greg, Candy, and daughters moved to the lake house which had been Greg's parents' home. The lake house has served as a popular family gathering place for many years. Shortly following their move, Greg was assigned to an evening shift with overtime on weekends and saw little of his family for a period of almost three months.

Kristin, age 4, attends a nursery school program. She is an active, healthy child.

Amber, age 9, attends third grade; she is a good student. Amber has had recurring bouts of bronchial asthma for many years which require periodic medical visits.

Candy and Greg are concerned about Amber's adjustment to a series of losses in her life. Amber was particularly close to her grandfather; her parents fear that she has not adequately mourned his death. During the final stages of her grandfather's illness last year, two family pets became ill and died. Most recently, just as she began to adjust to a new home and friends, Amber's father was placed on evening shift, resulting in little or no contact with the family. She has become withdrawn and lethargic; her parents worry at times about both her emotional and physical well-being.

APPENDIX C  
CLINICAL RATING SCALE (CRS) FOR THE CIRCUMPLEX  
MODEL OF MARITAL AND FAMILY SYSTEMS

Instructions for Use of the Clinical Rating Scale

After viewing the videotape, carefully read the descriptions for each concept and select the scale value that is most relevant for that family as a unit. Although some individuals or dyadic units might be classified in different ways, it is important to remember that the final classification should be based on how the family functions as a group.

A global rating should be made for each dimension (cohesion and adaptability). The global rating should be based on an overall evaluation or gestalt rather than a sum of the sub-scale ratings. Then it becomes possible to classify the family into one of the four levels of cohesion (disengaged, separated, connected, or enmeshed) and one of the four levels of family adaptability (rigid, structured, flexible, and chaotic).

TABLE 1: FAMILY COHESION

COUPLE/ FAMILY SCORE	TABLE 1: FAMILY COHESION			
	DISENGAGED 1	SEPARATED 2	CONNECTED 3	ENMESHED 4
EMOTIONAL BONDING	Extreme emotional separateness. Lack of family loyalty.	Emotional separateness, limited closeness. Occasional family loyalty.	Emotional closeness, some separateness. Loyalty to family expected.	Extreme emotional close- ness, little separateness. Loyalty to family demanded.
FAMILY INVOLVEMENT	Very low involvement or interaction. Infrequent effective responsiveness.	Involvement acceptable, personal distance preferred. Some affective responsiveness.	Involvement emphasized personal distance allowed. Affective interactions encouraged and preferred.	Very high involvement. Fusion; over-dependency; High affective responsive- ness and control.
MARITAL RELATIONSHIP	Extreme emotional separateness.	Emotional separateness, limited closeness.	Emotional closeness, some separateness.	Extreme closeness, fusion; limited separateness.
PARENT-CHILD RELATIONSHIP	Entrenched generational boundaries (impermeable).	Clear generational boundaries some p/c closeness (Permeable).	Clear generational boundaries with p/c closeness (Permeable).	Lack of generational boundaries (Diffuse).
INTERNAL BOUNDARIES TIME (physical & emotional) SPACE (physical & emotional)	<i>Separateness dominates</i> Time spent maximized Hardly time together. Separate space needed and preferred. Individual decision making. (Oppositional)	<i>More separateness than togetherness</i> Time alone important Some time together. Separate space preferred; sharing of family space. Individual decision making but joint possible.	<i>More togetherness than separateness</i> Time together important. Time alone permitted. Sharing family space. Private space respected. Joint decisions preferred.	<i>Togetherness dominates</i> Time together maximized. Little time alone permitted. Little private space permitted. Decisions subject to wishes of entire group.
EXTERNAL BOUNDARIES FRIENDS INTERESTS ACTIVITIES	<i>Mainly focused outside the family.</i> Individual friends seen alone. Disparate interests. Mainly separate activities.	<i>More focused outside than inside family.</i> Individual friendships seldom shared with family. Separate interests. More separate than shared activities.	<i>More focused inside than outside family.</i> Individual friendships shared with family. Some joint interests. More shared than individual activities.	<i>Mainly focused inside the family.</i> Family friends preferred limited individual friends. Joint interests mandated. Separate activities seen as disloyal.
GLOBAL COHESION RATING (1-4)	Very Low	Low to Moderate	Moderate to High	Very High

TABLE 2: FAMILY CHANGE (ADAPTABILITY)

COUPLE/ FAMILY SCORE	FAMILY CHANGE (ADAPTABILITY)			
	RIGID 1	STRUCTURED 2	FLEXIBLE 3	CHAOTIC 4
LEADERSHIP (control)	Authoritarian leadership. Parent(s) highly controlling.	Primarily authoritarian but some egalitarian leadership.	Egalitarian leadership with fluid changes.	Limited and/or erratic leadership. Parental control unsuccessful, rebuffed.
DISCIPLINE (for families only)	Autocratic "law & order". Strict, rigid consequences. Not lenient.	Somewhat democratic. Predictable consequences. Seldom lenient.	Usually democratic. Negotiated consequences. Somewhat lenient.	Laissez-faire and ineffective. Inconsistent consequences. Very lenient.
NEGOTIATION	Limited negotiations. Decisions imposed by parents.	Structured negotiations. Decisions made by parents.	Flexible negotiations. Agreed upon decisions.	Endless negotiations. Impulsive decisions.
ROLES	Limited repertoire, strictly defined roles.	Roles stable, but may be shared.	Role sharing and making. Fluid changes of roles.	Lack of role clarity, role ambiguity and role reversals.
RULES	Unchanging rules. Rules strictly enforced.	Few rule changes. Rules firmly enforced.	Some rule changes. Rules flexibly enforced.	Frequent rule changes. Rules inconsistently enforced.
GLOBAL ADAPTABILITY RATING (1-4)	Very Low	Low to Moderate	Moderate to High	Very High

The global rating is based on you overall evaluation, not on a sum score of the sub-scales.

APPENDIX D  
IMPACT ON FAMILY SCALE



# IMPACT ON FAMILY SCALE--COUNSELOR RATING VERSION

Instructions: Below are statements that people have made about living with a child with a chronic condition. For each statement, please indicate how you think the child's condition will impact the family on the videotape.

	Strongly Agree	Agree	Disagree	Strongly <u>Disagree</u>
<u>This family may find:</u>				
a. The child's condition causes financial problems for the family	1	2	3	4
b. Time is lost from work because of medical appointments	1	2	3	4
c. A family member must cut down the hours worked to care for the child	1	2	3	4
d. Additional income is needed in order to cover medical expenses	1	2	3	4
e. A member has to stop work because of the child's condition	1	2	3	4
f. Because of the child's condition, the family is not able to travel	1	2	3	4
g. People in the neighborhood treat them differently because of the child's condition	1	2	3	4
h. They have little desire to go out because of the child's condition	1	2	3	4
i. It is hard to find a reliable person to care for the children	1	2	3	4

	Strongly <u>Agree</u>	Agree	Disagree	Strongly <u>Disagree</u>
This family may find:				
j. Sometimes they have to change plans about going out at the last minute because of the child's condition	1	2	3	4
k. They see family and friends less because of the child's condition	1	2	3	4
l. They are a closer family because of what they have shared	1	2	3	4
m. They wonder whether this child should be treated "specially" or the same as a healthy child	1	2	3	4
n. Their relatives are understanding and helpful with the child	1	2	3	4
o. The parents think about not having more children because of the condition	1	2	3	4
p. The parents will discuss the child's problems together	1	2	3	4
q. They will try to treat the child as if she/he were healthy	1	2	3	4
r. They don't have much time left over for other family members after caring for the child	1	2	3	4
s. Relatives interfere and think they know what is best for the child	1	2	3	4

	Strongly <u>Agree</u>	Agree	Disagree	Strongly <u>Disagree</u>
This family may find:				
t. Their family gives up things because of the child's condition	1	2	3	4
u. Fatigue is a problem because of the child's condition	1	2	3	4
v. They live from day to day and don't plan for the future	1	2	3	4
w. Nobody understands the burden they carry	1	2	3	4
x. Traveling to the medical center is a strain on them	1	2	3	4
y. Learning to manage the child's condition makes the family feel better about itself	1	2	3	4
z. They worry about what will happen to their child in the future	1	2	3	4
aa. Sometimes they feel they live on a roller coaster, in crisis when the child's condition is acute, OK when things are stable	1	2	3	4

Modified by R. D. Miller, Ed.S.  
 Based on scale developed by Ruth E. K. Stein, M.D.  
 and Catherine K. Reissman, Ph.D.  
 Copyright 1978

## REFERENCES

- Abramowitz, C. V., & Dakecki, P. R. (1977). The politics of clinical judgments: Early empirical returns. Psychological Bulletin, 34, 460-476.
- Abramowitz, S. I., & Murray, J. (1983). Race effects in psychotherapy. In J. Murray & P. R. Abramson (Eds.), Bias in Psychotherapy (pp. 215-255). New York: Praeger.
- Alexander, F. (1939). Emotional factors in essential hypertension: Presentation of a tentative hypothesis. Psychosomatic Medicine, 1, 173-179.
- Alexander, F. (1941). Theoretical considerations. In T. M. French & F. Alexander (Eds.), Psychogenic factors in bronchial asthma: Part I: Psychosomatic Medicine Monograph IV (pp. 70-76). Washington: National Research Council.
- Alexander, F. (1950). Psychosomatic medicine. New York: W. W. Norton.
- American Association for Counseling and Development. (1989). AACD, divisions, and organizational affiliates membership report. Leadership Update, 1, 5-12.
- American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.
- Anderson, C. M., Reiss, D. J., & Hogarty, G. E. (1986). Schizophrenia and the family. New York: Guilford.
- Auerbach, A. H., & Johnson, M. (1977). Research on the therapist level of experience. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 84-102). New York: Pergamon Press.
- Barbarin, O., Hughes, D., & Chesler, M. (1985). Stress, coping, and marital functioning among parents of children with cancer. Journal of Marriage and the Family, 47, 473-480.

- Berger, A., & Morrison, T. L. (1984). Clinical judgments of easy vs difficult clients by counselor trainees. Journal of Clinical Psychology, 40, 1116-1122.
- Berry, J. O. (1987). A program for training teachers as counselors of parents of children with disabilities. Journal of Counseling and Development, 65, 508-509.
- Bishop, J. B., & Richards, T. F. (1984). Counselor theoretical orientation as related to intake judgments. Journal of Counseling Psychology, 31, 398-401.
- Bloom, B. L. (1988). Health psychology: A psychosocial perspective. Englewood Cliffs, NJ: Prentice Hall.
- Bradshaw, C. B., Stroher, B. C., & Biggs, D. A. (1986). Factors influencing beginning counselors' perceptions of client attractiveness. Rehabilitation Counseling Bulletin, 29, 218-224.
- Bronheim, S. P. (1978). Pulmonary disorders: Asthma and cystic fibrosis. In P. R. Magrab (Ed.), Psychological management of pediatric problems (Vol. 1, pp. 309-344). Baltimore: University Park Press.
- Brown, R. D. (1970). Experienced and inexperienced counselors' first impressions of clients and case outcomes: Are first impressions lasting? Journal of Counseling Psychology, 17, 550-558.
- Bruhn, J. G. (1983). The application of theory in childhood asthma self-help programs. Journal of Allergy & Clinical Immunology, 72, 561-577.
- Buchbinder, E. M., & Young, S. H. (1986). Psychoneuroimmunology: Past, present, and future. In S. H. Young, J. M. Rubin, & H. R. Daman (Eds.), Psychobiological aspects of allergic disorders (pp. 359-370). New York: Praeger.
- Burbeck, T. (1979). An empirical investigation of the psychosomatogenic family model. Journal of Psychosomatic Research, 23, 327-337.
- Burr, C. K. (1985). Impact on the family of a chronically ill child. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 24-40). San Francisco: Jossey-Bass.
- Buscaglia, L. (1983). The disabled and their parents: A counseling challenge. Thorofare, NJ: Slack.

- Campbell, D. T., & Stanley, J. C. (1966). Experimental and quasi-experimental designs for research. Chicago: Rand McNally.
- Campbell, T. L. (1986). Family's impact on health: A critical review: Family's impact on physical health. Family Systems Medicine, 4, 149-167.
- Clark, N. M., Feldman, C. H., Evans, D., Wasilewski, Y., & Levison, M. J. (1984). Changes in children's school performance as a result of education for family management of asthma. Journal of School Health, 54, 143-145.
- Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.
- Coyne, J. C., & Anderson, B. J. (1988). The "psychomatic family" reconsidered: Diabetes in context. Journal of Marital and Family Therapy, 14, 113-123.
- Coyne, J. C., & Anderson, B. J. (1989). The "psychosomatic family" reconsidered II: Recalling a defective model and looking ahead. Journal of Marital & Family Therapy, 15, 139-148.
- Creer, T. L. (1982). Asthma. Journal of Consulting & Clinical Psychology, 50, 912-921.
- Creer, T. L., Marion, R. J., & Creer, P. P. (1983). Asthma problem behavior checklist: Parental perceptions of the behavior of asthmatic children. Journal of Asthma, 20, 97-104.
- Creer, T. L., & Winder, J. A. (1986). Asthma. In K. A. Holroyd & T. L. Creer (Eds.), Self-management of chronic disease: Handbook of clinical interventions and research (pp. 269-303). Orlando: Academic Press.
- Dakof, G. A. (1987). At the starting gate: Research and theory on families and somatic health. Journal of Family Psychology, 1, 135-141.
- Darling, R. B. (1979). Families against society: A study of reactions to children with birth defects. Beverly Hills: Sage Publications.
- Darling, R. B. (1983). Parent-professional interaction: The roots of misunderstanding. In M. Seligman (Ed.), The family with a handicapped child: Understanding and treatment (pp. 95-121). New York: Grune & Stratton.

- Drotar, D. (1981). Psychological perspectives on chronic childhood illness. Journal of Pediatric Psychology, 6, 211-228.
- Drotar, D., Crawford, P., & Bush, M. (1984). The family context of childhood chronic illness: Implications for psychosocial intervention. In M. G. Eisenberg, L. C. Sutkins, & M. A. Jansen (Eds.), Chronic illness and disability through the life span: Effects on self and family (pp. 103-129). New York: Springs.
- Dunbar, H. F. (1954). Emotions and bodily changes: A survey of literature on psychosomatic interrelationships (4th ed.). New York: Columbia University.
- Dunst, C. J., Trivette, C. M., & Cross, A. H. (1986). Roles and support networks of mothers of handicapped children. In R. R. Fewell & P. F. Vadasy (Eds.), Families of handicapped children: Needs and support across the life span (pp. 167-192). Austin: Pro-Ed.
- Duvall, E. M. (1977). Marriage and family development. Philadelphia: Lippincott.
- Elson, R. R., & Snow, B. M. (1986). Attitudes toward people with disabilities as expressed by rehabilitation professionals. Rehabilitation Counseling Bulletin, 29, 284-286.
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1982). The McMaster family assessment device. Journal of Marital and Family Therapy, 9, 171-180.
- Featherstone, H. (1980). A difference in the family: Life with a disabled child. New York: Basic Books.
- Fewell, R. R. (1986). A handicapped child in the family. In R. R. Fewell & P. F. Vadasy (Eds.), Families of handicapped children: Needs and supports across the life span (pp. 3-34). Austin: Pro-Ed.
- Forman, B. D. (1986). Citation classics in family therapy. Journal of Marital and Family Therapy, 12, 97-100.
- Foster, M., & Berger, M. (1985). Research with families with handicapped children: A multilevel systemic perspective. In L. L'Abate (Ed.), The handbook of family psychology and therapy (Vol. 2, pp. 741-780). Homewood, IL: Dorsey Press.

- Fox, D. C. (1979). Shoe of the other foot: Parents teach professionals. Education Unlimited, 1 (5), 36-37.
- Freeman, E. H., Feingold, B. F., Schlesinger, K., & Gorman, F. J. (1964). Psychological variables in allergic disorders: A review. Psychosomatic Medicine, 26, 543-575.
- French, T. M., & Alexander, F. (Eds.). (1941). Psychogenic factors in bronchial asthma. Psychosomatic Medicine Monographs, 4 (Pt. 1).
- Freud, S. (1961). The standard edition of the complete psychological works of Sigmund Freud (Vol. 11). London: Hogarth Press. (Original work published 1910)
- Friedman, A. S., Utada, A., & Morrissey, M. R. (1987). Families of adolescent drug users are "rigid": Are these families either "disengaged" or "enmeshed," or both? Family Process, 26, 131-148.
- Golbert, T. M. (1985). Psychiatric aspects of allergic diseases. In R. Patterson (Ed.), Allergic diseases: Diagnosis and management (3rd ed.) (pp. 730-749). Philadelphia: J. B. Lippincott.
- Gonzalez, S., Steinglass, P., & Reiss, D. (1989). Putting the illness in its place: Discussion groups for families with chronic medical illnesses. Family Process, 28, 69-87.
- Goodyear, R. K. (1983). Patterns of counselors' attitudes toward disability groups. Rehabilitation Counseling Bulletin, 26, 181-184.
- Greenwood, R. (1987). Expanding community participation by people with disabilities: Implications for counselors. Journal of Counseling & Development, 66, 185-188.
- Grotevant, H. D., & Carlson, C. I. (1989). Family assessment: A guide to methods and measures. New York: Guilford.
- Gurman, A. S., Kniskern, D. P., & Pinsof, W. (1986). Research on the process and outcome of marital and family therapy. In S. Garfield & A. Bergin (eds.), Handbook of psychotherapy and behavior change (3rd ed.) (pp. 656-624). New York: John Wiley.



- Habeck, R. V. (1984). Ethical issues in lifestyle counseling for adjustment to disability. In W. R. Rule (Ed.), Lifestyle counseling for adjustment to disability (pp. 305-317). Rockville, MD: Aspen Systems.
- Hare-Mustin, R. T., & Lamb, S. (1984). Family counselors' attitudes toward women and motherhood: A new cohort. Journal of Marital and Family Therapy, 10, 419-421.
- Harris, S. L. (1983). Families of the developmentally disabled: A guide to behavioral intervention. New York: Pergamon.
- Hatfield, A. (1982). Therapist and families: Worlds apart. Hospital and Community Psychiatry, 33, 513.
- Hatfield, E., & Perlmutter, M. S. (1983). Social-psychological issues in bias: Physical attractiveness. In J. Murray & P. R. Abramson (Eds.), Bias in psychotherapy (pp. 53-83). New York: Praeger.
- Henderson, G., & Bryan, W. V. (1984). Psychological aspects of disability. Springfield, IL: Charles C. Thomas.
- Hobbs, N., & Perrin, J. M. (Eds.). (1985). Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies. San Francisco: Jossey-Bass.
- Hobbs, N., Perrin, J. M., & Iveys, H. T. (1985). Chronically ill children and their families: Problems, prospects, and proposals from the Vanderbilt study. San Francisco: Jossey-Bass.
- Hollis, J. W., & Wantz, R. A. (1986). Counselor preparation 1986-89: Programs, personnel, and trends (6th ed.). Muncie, IN: Accelerated Development.
- Hopkins-Best, M. (1987). The effects of students' sex and disability on counselor's agreement with post-secondary goals. School Counselor, 35, 28-33.
- Huck, S. W., Cormier, W. H., & Bounds, W. G. (1974). Reading statistics and research. New York: Harper & Row.
- Hurley, D. (1987). A sound mind in an unsound body: Chronically ill children benefit greatly from a comprehensive mix of medical, psychological and social therapy. Psychology Today, 21 (8), 34-38, 43.

- Jessop, D. J., Reissman, C. K., & Stein, R. E. (1988). Chronic childhood illness and maternal mental health. Journal of Developmental and Behavioral Pediatrics, 9, 147-156.
- Johnson, H. C. (1987). Biologically based deficit in the identified patient: Indications for psychoeducational strategies. Journal of Marital and Family Therapy, 13, 337-348.
- Johnson, S. B. (1986). The family and the child with chronic illness. In D. C. Turk & R. D. Kerns (Eds.), Health, illness, and families: A life-span perspective (pp. 220-254). New York: Wiley.
- Kaplan, H. I., & Sadock, B. J. (1985). Modern synopsis of comprehensive textbook of psychiatry (4th ed.). Baltimore, MD: Williams & Wilkins.
- Kazak, A. E. (1989). Families of chronically ill children: A systems and social-ecological model of adaptation and challenge. Journal of Consulting and Clinical Psychology, 57, 25-30.
- Kazak, A. E., Reber, M., & Snitzer, L. (1988). Childhood chronic disease and family functioning: A study of phenylketonuria. Pediatrics, 81, 224-230.
- Kemmer, F. W., Bisping, R., Steingruber, H. J., Baer, H., Hardtmann, F., Schlaghecke, R., & Berger, M. (1986). Psychosocial stress and metabolic control in patients with Type I diabetes mellitus. New England Journal of Medicine, 314, 1078-1084.
- Kog, E., Vandereycken, W., & Vertommen, H. (1985). The psychosomatic family model: A critical analysis of family interaction. Journal of Family Therapy, 7, 31-44.
- Kog, E., Vertommen, H., & Vandereycken, W. (1987). Minuchin's psychosomatic family model revised: A concept validation study using a multitrait-multimethod approach. Family Process, 26, 235-253.
- Kubler-Ross, E. (1969). On death and dying. New York: MacMillan.
- Kuzemko, J. A. (1980). Natural history of childhood asthma. Journal of Pediatrics, 97, 886-892.

- Laborde, P. R., & Seligman, M. (1983). Individual counseling with parents of handicapped children: Rationale and strategies. In M. Seligman (Ed.), The family with a handicapped child: Understanding and treatment (pp. 261-284). New York: Free Press.
- Leffert, F. (1985). Asthma. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 366-380). San Francisco: Jossey-Bass.
- Liebman, R., Minuchin, S., & Baker, L. (1974). The use of structural family therapy in the treatment of intractable asthma. American Journal of Psychiatry, 131, 535-540.
- Liebman, R., Minuchin, S., Baker, L., & Rosman, B. (1976). The role of the family in the treatment of childhood asthma. In P. J. Guerin (Ed.), Family therapy theory and practice (pp. 309-324). New York: Gardner.
- Lin, N., Simeone, R. S., Ensel, W. M., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and an empirical test. Journal of Health and Social Behavior, 20, 108-119.
- Loader, P., Kinston, W., & Stratford, J. (1980). Is there a "psychosomatogenic" family? Journal of Family Therapy, 2, 311-327.
- Longo, D. C., & Bond, L. (1984). Families of the handicapped child: Research and practice. Family Relations, 33, 57-65.
- Magrab, P., & Calcagno, P. (1978). Psychological impact of chronic pediatric conditions. In P. R. Magrab (Ed.), Psychological management of pediatric problems (Vol. 1, pp. 3-14). Baltimore: University Park Press.
- Margolis, R. L., & Rungta, S. A. (1986). Training counselors for work with special populations: A second look. Journal of Counseling and Development, 64, 642-644.
- Marteau, T. M., & Johnston, M. (1986). Determinant of beliefs about illness: A study of parents of children with diabetes, asthma, epilepsy, and no chronic illness. Journal of Psychosomatic Research, 30, 673-686.

- Martin, W. E., Scalia, V. A., Gay, D. A., & Wolfe, R. R. (1982). Beginning rehabilitation counselors' attitudes toward disabled person. Journal of Applied Rehabilitation Counseling, 13(2), 14-16.
- Massie, R. K. (1985). The constant shadow: Reflections on the life of a chronically ill child. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 13-23). San Francisco: Jossey-Bass.
- Masters, J. C., Cerreto, M. C., & Mendlowitz, D. R. (1983). The role of the family in coping with childhood chronic illness. In T. G. Burish & L. A. Bradley (Eds.), Coping with chronic disease: Research and application (pp. 381-407). New York: Academic Press.
- Mattsson, A. (1975). Psychological aspects of childhood asthma. Pediatric Clinics of North America, 22, 77-88.
- Matus, I. (1981). Assessing the nature and clinical significance of psychological contributions to childhood asthma. American Journal of Orthopsychiatry, 51, 327-341.
- McCormick, M. C., Charney, E. B., & Stemmler, M. M. (1986). Assessing the impact of a child with spina bifida on the family. Developmental Medicine and Child Neurology, 28, 53-61.
- McCubbin, H. I., McCubbin, M. A., & Cauble, E. (1979). CHIP: Coping health inventory for parents (Form A). (Available from Family Social Science, University of Minnesota, St. Paul, MN 55108)
- McCubbin, H. I., McCubbin, M. A., Patterson, J. A., Cauble, A. E., Wilson, L. R., & Warwick, W. (1983). CHIP: Coping health inventory for parents: An assessment of parental coping patterns in the case of the chronically ill child. Journal of Marriage and the Family, 45, 359-370.
- McLean, J. A., & Ching, A. Y. T. (1973). Fillip study of relationships between family situation and bronchial asthma in children. Journal of the American Academy of Child Psychiatry, 12, 142-161.
- McLoughlin, J., Nall, M., Isaacs, B., Petrosko, J., Kairob, J., & Lindsey, B. (1983). The relationship of allergies and allergy treatment to school performance and study behavior. Annals of Allergy, 51, 506-510.

- Melamed, B. G., & Siegel, L. J. (1975). Reduction of anxiety in children facing hospitalization and surgery by use of filmed modeling. Journal of Consulting and Clinical Psychology, 43, 511-521.
- Meyer, D. J. (1986). Fathers of handicapped children. In R. R. Fewell & P. F. Vadasy (Eds.), Families of handicapped children: Needs and supports across the life span (pp. 35-73). Austin, TX: Pro-Ed.
- Mintz, J. (1972). What is "success" in psychotherapy? Journal of Abnormal Psychology, 80, 11-19.
- Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Milman, L., & Todd, T. C. (1975). A conceptual model of psychosomatic illness in children. Archives of General Psychiatry, 32, 1031-1038.
- Minuchin, S., Montalvo, B., Guerney, B. G., Rosman, B. L., & Schermer, F. (1967). Families of the slums: An exploration of their structure and treatment. New York: Basic Books.
- Minuchin, S., Rosman, B. L., Baker, L., & Liebman, R. (1978). Psychosomatic families: Anorexia nervosa in context. Cambridge: Harvard University Press.
- Moe, J. H., & Byrd, J. A. (1987). Idiopathic scoliosis. In D. S. Bradford, J. E. Lonstein, J. H. Moe, J. W. Ogilvie, & R. B. Winter (Eds.), Moe's textbook of scoliosis and other spinal deformities (pp. 191-232). Philadelphia: W. B. Saunders.
- Moeller, C. T. (1986). The effect of professionals on the families of a handicapped child. In R. R. Fewell & P. F. Vadasy (Eds.), Families of handicapped children: Needs and supports across the life span (pp. 149-166). Austin, TX: Pro-Ed.
- Mori, A. A. (Ed.). (1983). Families of children with special needs: Early intervention techniques for the practitioner. Rockville, MD: Aspen.
- Moroney, R. (1981). Public social policy: Impact on families with handicapped children. In J. L. Paul (Ed.), Understanding and working with parents of children with special needs (pp. 168-204). New York: Holt, Rhinehart, & Winston.

- Mott, S. E., Fewell, R. R., Lewis, M., Meisels, S. J., Shonkoff, J. P., & Simeonsson, R. J. (1986). Methods for assessing child and family outcomes in early childhood special education programs: Some views from the field. Topics in Early Childhood Special Education, 6(2), 1-15.
- National Institute of Handicapped Research. (1985). Summary of data on handicapped children and youth. Washington: Department of Education.
- Nicolas, D. R., Gerstein, L. H., & Keller, K. E. (1988). Behavioral medicine and the mental health counselor: Roles and interdisciplinary collaboration. Journal of Mental Health Counseling, 10, 79-94.
- Nicolas, D. R., & Keller, K. E. (1988). Behavioral medicine and the mental health counselor. Journal of Mental Health Counseling, 10, 67-68.
- Nieder, J. M. (1986). Evaluation and treatment of allergic disorders in children: A psychiatric perspective. In S. H. Young, J. M. Rubin, & H. R. Daman (Eds.), Psychobiological aspects of allergic disorders (pp. 233-249). New York: Praeger.
- Olson, D. H. (1988a). Circumplex model of family systems VIII: Family assessment and intervention. Journal of Psychotherapy and the Family, 4, 7-49.
- Olson, D. H. (1988b). Clinical Rating Scale (CRS) for the Circumplex Model of Marital and Family Systems (rev. ed.). St. Paul: Family Social Science, University of Minnesota.
- Olson, D. H., McCubbin, H. I., Barnes, H., Larsen, A., Muxen, M., & Wilson, M. (1983). Families: What makes them work. Beverly Hills: Sage.
- Olson, D. H., Russell, C., & Sprenkle, D. H. (1983). Circumplex model VI: Theoretical update. Family Process, 22, 69-83.
- Opirhory, G., & Peters, G. A. (1982). Counseling intervention strategies for families with the less than perfect newborn. Personnel and Guidance Journal, 60, 451-455.
- Perrin, J. M. (1985). Preface. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. ix-xii). San Francisco: Jossey-Bass.

- Perrin, J. M., & Ireys, H. T. (1985). Preface. In N. Hobbs, J. M. Perrin, & H. T. Ireys, Chronically ill children and their families: Problems, prospects, and proposals from the Vanderbilt study (pp. xvii-xxiii). San Francisco: Jossey-Bass.
- Peterson, G., & Bradley, R. W. (1980). Counselor orientation and theoretical attitudes toward counseling: Historical perspective and new data. Journal of Counseling Psychology, 27, 554-560.
- Pinsof, W. M. (1981). Family therapy process research. In A. S. Gurman & D. P. Kniskern (Eds.), Handbook of family therapy (pp. 699-741). New York: Brunner/Mazel.
- Pless, I. B., & Douglas, J. W. B. (1971). Chronic illness in childhood: Part I. Epidemiological and clinical characteristics. Pediatrics, 47, 405-414.
- Pless, I. B., & Perrin, J. M. (1985). Issues common to a variety of illnesses. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 41-60). San Francisco: Jossey-Bass.
- Pless, I. B., & Pinkerton, P. (1975). Chronic childhood disorders: Promoting patterns of adjustment. Chicago: Year Book Medical Publishers.
- Pless, I. B., & Satterwhite, R. B. (1975). Chronic illness. In R. Haggerty, K. Roghmann, & I. B. Pless (Eds.), Child health and the community (pp. 78-93). New York: Wiley.
- Prochaska, J., & Norcross, J. C. (1983). Contemporary psychotherapists: A national survey of characteristics, practices, and attitudes. Psychotherapy: Theory, Research, and Practice, 20, 161-173.
- Raimbault, G., Cachén, O., Limal, J. M., Elincheff, C., & Rappaport, L. (1975). Aspects of communication between patients and doctors: An analysis of the discourse in medical interviews. Pediatrics, 55, 401-405.
- Rangaswamy, L. (1983). Curvatures of the spine. In J. Umbreit (Ed.), Physical disabilities and health impairment: An introduction (pp. 59-73). Columbus, OH: Charles E. Merrill.



- Rice, D., Gurman, A., & Razin, A. (1974). Therapist sex, "style" and theoretical orientation. Journal of Nervous and Mental Disease, 159, 413-421.
- Rolland, J. S. (1987a). Chronic illness and the life cycle: A conceptual framework. Family Process, 26, 203-221.
- Rolland, J. S. (1987b). Family systems and chronic illness: A typological model. Journal of Psychotherapy and the Family, 3, 143-168.
- Rosman, B. L., & Baker, L. (1988). The "psychosomatic family" reconsidered: Diabetes in context--A reply. Journal of Marital and Family Therapy, 14, 133-137.
- Ruesch, J. (1948). The infantile personality. Psychosomatic Medicine, 10, 134-144.
- Sattler, J. M. (1977). The effects of therapist-client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 252-290). New York: Pergamon Press.
- Sax, G. (1980). Principles of educational and psychological measurement and evaluation (2nd ed.). Belmont, CA: Wadsworth.
- Seligman, M. (1979). Strategies for helping parents of handicapped children. New York: Free Press.
- Seligman, M. (1985). Handicapped children and their families. Journal of Counseling and Development, 64, 274-277.
- Shontz, F. C. (1977). Physical disability and personality: Theory and recent research. In J. Stubbs (Ed.), Social and psychological aspects of disability: A handbook for practitioners (pp. 333-353). Baltimore: University Park Press.
- Sonnenschein, P. (1981). Parents and professionals: An uneasy relationship. Teaching Exceptional Children, 14, 62-65.
- Starfield, B. (1985). The state of research on chronically ill children. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 109-132). San Francisco: Jossey-Bass.



- Stein, R. E. K., & Jessop, D. J. (1982). A non-categorical approach to chronic childhood illness. Public Health Research, 97, 354-362.
- Stein, R. E. K., & Jessop, D. J. (1984). General issues in the care of children with chronic physical conditions. Pediatric Clinics of North America, 31, 189-198.
- Stein, R. E. K., & Reissman, C. K. (1978). Impact on family. (Available from Department of Pediatrics, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, NY 10461)
- Stein, R. E. K., & Reissman, C. K. (1980). The development of an impact-on-family scale: Preliminary findings. Medical Care, 17, 465-472.
- Stern, A. (1981). Asthma and emotion. New York: Gardner.
- Stricker, G., & Shafron, R. (1983). Gender and psychotherapy: A review of the empirical literature. In J. Murray & P. R. Abramson (Eds.), Bias in psychotherapy (pp. 192-214). New York: Praeger.
- Sutton, R. G., & Kessler, M. (1986). National study of the effects of clients' socioeconomic status on clinical psychologists' professional judgments. Journal of Consulting and Clinical Psychology, 54, 275-276.
- Surwit, R. S., Feinglos, M. N., & Scovern, A. W. (1983). Diabetes and behavior: A paradigm for health psychology. American Psychologist, 38, 255-263.
- Tringo, J. L. (1970). The hierarchy of preference toward disability groups. Journal of Special Education, 4, 295-306.
- Turk, D. C., & Kerns, R. D. (1986). The family in health and illness. In D. C. Turk and R. D. Kerns (Eds.), Health, illness, and families: A life-span perspective (pp. 1-22). New York: Wiley.
- Turnbull, A P., Summers, J. A., & Brotherson, M. J. (1986). Family life cycle: Theoretical and empirical implications and future directions for families with mentally retarded members. In J. J. Gallagher & P. M. Vietze (Eds.), Families of handicapped persons: Research, programs, and policy issues (pp. 45-65). Baltimore: Paul H Brooks.

- Turnbull, A. P., & Turnbull, H. R. (1986). Families, professionals and exceptionality: A special partnership. Columbus, OH: Charles E. Merrill.
- Turnbull, H. R., & Turnbull, A. P. (1985). Parents speak out: Then and now. Columbus, OH: Charles E. Merrill.
- Vacc, N. A., & Loesch, L. C. (1987). Counseling as a profession. Muncie, IN: Accelerated Development.
- Walker, D. K., & Jacobs, F. H. (1985). Public school programs for chronically ill children. In N. Hobbs & J. M. Perrin (Eds.), Issues in the care of children with chronic illness: A sourcebook on problems, services, and policies (pp. 615-655). San Francisco: Jossey-Bass.
- Walsh, F., & Anderson, C. (1987). Chronic disorders and families: An overview. Journal of Psychotherapy and the Family, 3(3), 3-18.
- Weicker, L., Jr. (1985). Sonny and public policy. In H. R. Turnbull & A. P. Turnbull (Eds.), Parents speak out: Then and now (pp. 281-287). Columbus, OH: Charles E. Merrill.
- Whitt, J. K. (1984). Childrens' adaptation to chronic illness and handicapping conditions. In M. G. Eisenberg, L. C. Sutkin, & M. A. Jansen (Eds.), Chronic illness and disability through the life span: Effects on self and family (pp. 69-102). New York: Springer.
- Wilson, C. P. (1980-1981). Parental overstimulation in asthma. International Journal of Psychoanalytic Psychotherapy, 8, 601-621.
- Wirsching, M., & Stierlin, H. (1979). Family dynamics and family psychotherapy or psychosomatic disorders. Psychotherapy and Psychosomatics, 32, 128-133.
- Wolfer, J. A., & Visintainer, M. N. (1975). Pediatric surgical patients' and parents' stress responses and adjustment as a function of psychological preparation and stress-point nursing care. Nursing Research, 24, 244-255.
- Wright, G. N. (1980). Total rehabilitation. Boston: Little, Brown & Company.
- Young, P. (1980). Asthma and allergies: An optimistic future (NIH No. 80-388). Washington, DC: Department of Health and Human Services.

Zacharowicz, L. (1986). Stress and asthma: Psychobiologic considerations. In S. H. Young, J. M. Rubin, & H. Daman (Eds.), Psychobiological aspects of allergic disorders (pp. 253-325). New York: Praeger.

## BIOGRAPHICAL SKETCH

Rose Diane ("Mickie") Michelfelder Miller is the first of two daughters born to Ervin and Eva Michelfelder. She was born on August 3, 1948, at Cullman, Alabama. She graduated from Hanceville High School, Hanceville, Alabama. She attended Samford University, Birmingham, Alabama, for undergraduate education and received the Bachelor of Arts degree in history, with honors, in 1970.

Mickie married Tony Miller in 1970 and moved to Louisville, Kentucky, where Tony was enrolled as a theology student at the Southern Baptist Theological Seminary. She was employed in 1972 by the Madison State Hospital, Madison, Indiana, as a Vocational Specialist and Adolescent Case Worker. In 1974, she moved to Copperas Cove, Texas, where Tony served as a Chaplain at Fort Hood Army Base. Her first child, Adam, was born in 1974, and her second child, Susan, was born in 1976.

In 1977, Mickie moved to Southgate, Michigan. While in Michigan, she served on the Board of Directors of Friendship House, a community center in Hamtramck, an inner-city neighborhood in Detroit.

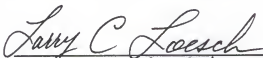
In 1981, she enrolled as a graduate student in the Department of Counselor Education at the University of Florida. She received the Master of Education and Educational Specialist degrees in 1984.

Mickie was accepted into the doctoral program in Counselor Education at the University of Florida in 1984. Her area of specialization was mental health counseling focusing on work with families. She was admitted to candidacy in 1988.

In the Fall of 1984, Mickie was employed as Graduate Assistant to the Practicum and Internship Coordinator in the Counselor Education Department, University of Florida. In 1989, she was hired as a Counselor in the Children's Outpatient Program, Mental Health Services, Inc., Gainesville, Florida. In the Summer of 1989, she transferred to Bridge House Residential Substance Abuse Treatment Center as Family Counselor. She was licensed as a Mental Health Counselor by the State of Florida in 1990. She is currently employed as Senior Clinician coordinating family programs at the Sid Martin Bridge House.

Her primary goal is to expand her career as a mental health practitioner. She also hopes to pursue grants in the area of counselor education.

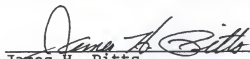
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



---

Larry C. Loesch, Chair  
Professor of Counselor Education

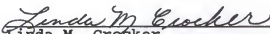
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



---

James H. Pitts  
Assistant Professor of Counselor  
Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



---

Linda M. Crocker  
Professor of Foundations of  
Education

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December, 1990

---

Dean, College of Education

---

Dean, Graduate School